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Using Social Control to Change the Behaviour of Pregnant Women Who Use Alcohol: An Ethical and Empirical Analysis

by

©

Erin L. Cooper

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The End!

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Chapter 1: Introduction

The Nature of The Problem

Communities have a legitimate vested interest in the health status of children. Links between early childhood development and health status later in life are well established and provide an important arena within which to study population health.[1] Many indicators that signify whether babies are off to a "healthy start" (e.g., birth weight or premature birth) are determined *before* birth by the health behaviours of pregnant women. Low birth weight and fetal alcohol syndrome/effects are examples of conditions that can have deleterious health effects over a child's entire lifetime. Both of these conditions are linked to maternal use of substances during pregnancy (e.g., tobacco, alcohol; Alberta Health and Wellness, 1999).

In the case of alcohol, and the fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE) that can result from a pregnant woman drinking alcohol, the physical, psychological and behavioural effects on children are tragic and their opportunities to flourish in life are severely limited before they are even born. Given this sad reality, it is reasonable and intuitive that the public has a strong interest and motivation to ensure that women make healthy decisions during pregnancy. This thesis provides an empirical and ethical analysis of how, why, and to what end society goes about controlling the behaviour of pregnant women who use alcohol.

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[1] A good review of this literature can be found in: Wadsworth, Michael, "Early Life" Ch 3 in Marmot and Wilkinson (Eds) Social Determinants of Health, Oxford University Health, 1999.

Personal autonomy encompasses an individual's fundamental right to make decisions in relation to his or her health and health care. Legislation around informed consent, the right to refuse treatment, and personal directives has cemented this ethical shift away from medical paternalism into Canadian law.[2] However issues of substance use in general, and substance use during pregnancy in particular, add complexity to this dialogue as society attempts to strike a balance between respect for individual autonomy and the amelioration of the negative health impacts of addiction on society. A variety of formal social control mechanisms (e.g., incarceration and forced treatment), and informal social control tactics (e.g., interpersonal pressures and threats), can be used to try to change the behaviour of people who use and abuse alcohol. Some research suggests that the use of coercive tactics to force individuals into addiction treatment programs is associated with increased drop out and relapse rates (Loneck, 1996). This suggestion is consistent with theories of motivation such as *self-determination theory,* which propose that controlled motivation (e.g., coercion, pressure, threats that originate external to the self) undermine an individual's sense of autonomy and furthermore diminish the opportunity for self-motivated behaviour change (Ryan, 1993). These theories will be described in further detail in the literature review which comprises Chapter 2 of this thesis.

Concerns about infringing on autonomous choice is further complicated in the case of the pregnant woman for several reasons. For example, the question of whether or not a fetus should have any legal status has been hotly debated in Canadian courts (for

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2 See for example Alberta's "Personal Directives Act", consolidated 1997 and Etchells et

example abortion, forced caesarean sections, feticide). As exemplified in the case of debates about abortion, there is little consensus in Canada over whether or not a *fetus* is a *person*. Beyond the legal realm, there are a multitude of moral perplexities to be contended with. Questions here include: Once a woman decides not to have an abortion, is she under some sort of moral obligation to provide a certain level of care for the fetus? Does a woman have a moral obligation to undergo medical procedures or to make *sacrifices* in her lifestyle choices in the interests of the fetus she carries? What are society's moral obligations in ensuring a healthy environment for a developing fetus that will one day be a member of the community?

Adding further richness and complexity to these issues is the concern for the rights of women in general. Feminist literature has illuminated ways in which historical societal norms and medical culture have served to undermine the rights of women, medicalize their experiences, and reduce their roles to those contributing to reproduction (Michinson, 1998). With these historical tendencies serving as a backdrop to this issue, it becomes increasingly apparent that it is important to recognize and protect the rights of pregnant women as *individuals*. These legal and moral complexities are described in further detail in Chapters 2 and also 4 of this thesis.

With public participation in policy making increasingly being valued in the health care arena, public attitudes represent a key source of data to inform interpersonal actions as well as policy decisions in relation to these issues. However little empirical research has addressed this issue to date. Investigating public attitudes surrounding social control

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al. (1996), "Bioethics for Clinicians: 1. Consent", CMAJ. July 15; 155(2):177-180.

of pregnant women using alcohol may help to identify levels of support for legislation and policies designed to ensure fetal health.

Overview of Thesis

The question of what (if any) social control tactics can legitimately be used to modify the behaviour of pregnant women using alcohol is particularly complex. For example, a psychologist might ask "will addiction treatment that is coerced have any lasting effect on a woman's health behaviour decisions?" An ethicist might ask "how do we negotiate the harms done to an unborn fetus versus the right of a woman to make autonomous choices, and what are the values at stake?" A feminist might ask "if we infringe on a woman's freedom in any way, simply because she is pregnant, what effect might that have on the roles and rights afforded to women in general?" Finally, a policy maker might want to know "how do members of the community view this health issue and how do they think it should be addressed?" Thus it becomes clear that any thorough analysis of this issue will necessitate interdisciplinary research and the use of mixed research methodologies in order to integrate these divergent perspectives.

This thesis will analyze the use of social control strategies for pregnant women who use alcohol by drawing on: (1) psychological literature on addiction, addiction treatment and theories of motivation, (2) ethical literature examining theories of autonomy and the justified uses of social control, (3) feminist ethical literature investigating the rights of women, particularly in their reproductive roles; and (4) empirical data describing public attitudes towards social control. I will then integrate the findings from these sources by developing a framework that could also be applied to other research questions using empirical and conceptual investigatory techniques.

Chapter 2 of this thesis consists of a literature review providing information relevant to this issue from the fields of public health, ethics, feminism, psychology, and law. In Chapter 3, I describe an empirical study which investigated public attitudes toward the appropriateness of various social control mechanisms that could be used for pregnant women who use alcohol. Chapter 4 consists of a normative ethical analysis of this issue and will seek answers to the question of what social control mechanisms imposed on pregnant women using alcohol are ethically justifiable. Chapter 5 compares, contrasts and then integrates the findings from the various data sources that were explored. Finally Chapter 6 will offer conclusions and recommendations.

Research Objectives

Four broad objectives were addressed in this research:

1. To complete a broad literature review across diverse fields of research to determine what various fields have to say about the question of whether social control tactics that could be used for pregnant women who drink alcohol are justifiable.
2. To document public attitudes surrounding the legitimacy of various social control tactics for "*people with an alcohol problem*" versus "*pregnant women with an alcohol problem*" to determine whether public attitudes differ for people in general versus pregnant women, and to explore whether attitudes differ between respondent subgroups (e.g., male vs. female).
3. To engage in a normative ethical analysis, from a public health perspective, of the use of social control mechanisms to modify the behaviour of pregnant women who drink alcohol.

4. To determine how the information from various data sources and methodologies can be integrated.

Results of this study will be used to inform (a) psychosocial research on health attitudes, perceptions of addiction and pregnancy, and conceptions of pregnant substance abusers (b) bioethical literature regarding boundaries between justified social control versus infringements upon autonomy (c) feminist literature surrounding societal structures, attitudes, and belief systems that influence rights and opportunities afforded to women, (d) analyses of programs and policy with regard to substance abusing pregnant women, and (e) public health literature with regard to using interdisciplinary research and mixed methodologies.

Chapter 2: Background and Literature Review

Overview

This chapter will a) introduce the frameworks forming the backdrop for this thesis, b) describe some of the concepts that will be discussed throughout this research, and c) provide a multidisciplinary review of the relevant background literature to the issues at hand. This review begins with some background on fetal alcohol syndrome/effects, alcohol use among women, and an introduction to the population health concepts that heavily influence this research. Next I will outline policy and legal responses to this public health issue, including previous empirical research investigating public attitudes towards social control of substance abusers and of pregnant women. The review then moves into the theoretical literature to explore concepts of autonomy.

The Public Health Issue

Fetal Alcohol Syndrome/Fetal Alcohol Effects

In a relationship unlike any other, a fetus growing inside a woman's womb is completely and uniquely dependent on the health choices made by its mother. For over 25 years alcohol has been a known teratogen (Eustace et al., 2003). Alcohol consumption during pregnancy can result in lower birth weight, a higher risk of pre-term birth, higher risk of being small for gestational age, and perhaps the most devastating and causally linked result: fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE, Health Canada, 1996). To date, research has not positively ascertained the exact mechanism(s) by which alcohol damages the developing brain, but they appear to be numerous, inter-related and highly complex (Eustace et al., 2003, Alcohol Research and Health, 2000). The physical, psychological and behavioural impacts on children born with these alcohol related birth defects is tragic and their opportunities to flourish in life are severely limited before they are even born.

The diagnosis of FAS refers to a specific set of disabilities including:

- Prenatal and/ or postnatal growth restriction;
- Characteristic facial features: thin upper lip, small eye openings, flat elongated philtrum, small chin flattened cheekbones; and
- Central nervous system involvement: ie. developmental delays, behaviour dysfunction, learning disabilities. (Health Canada, 1996, Eustace et al., 2003)

A diagnosis of FAE describes a case where some, but not all, of these characteristics are present in the child. Since many of these diagnostic criteria may not be apparent at birth, and since these effects may often be confused with other health problems, the incidence and prevalence rates of FAS and FAE are difficult to obtain. However, FAS has been recognized as one of the leading causes of preventable birth defects and developmental delay in children (Health Canada, 1996). Health Canada's Canadian Perinatal Surveillance System reports the estimated national rate of FAS to be 1 to 2 per 1000 live births, indicating that more than 350 children are born with FAS each year. The incidence of FAE may be several times higher than this (Health Canada, 1996) and the incidence of both FAS and FAE appear to be much higher in some Aboriginal communities (Canadian Perinatal Surveillance System, 1998).

It has been estimated that the additional health care, education and social services required by an individual suffering these effects, costs about $1.4 million over their lifetime (Square, 1997). In Alberta, the Alberta Alcohol and Drug Abuse Commission

(AADAC, 2001) reports that an estimated 29% of children in government care have likely been affected by their mother's use of alcohol during pregnancy.

Although there does seem to be a relationship between the amount of alcohol a woman drinks (and the stage in pregnancy she drinks) and the effects her drinking has on the child who is born, no "safe" amount of alcohol use during pregnancy has been determined (Canadian Perinatal Surveillance System, 1998, Health Canada, 1996, Eustace et al., 2003). Therefore, overwhelmingly researchers and physicians have stated that the best choice for the safety of the unborn fetus is not to consume any alcohol at all while pregnant (Eustace et al., 2003). The Canadian Perinatal Surveillance System, drawing from data collected through Statistics Canada in the 1994 National Population Health Survey, and the 1994/95 National Longitudinal Survey on Children and Youth, reported that 17-25% of women drank alcohol at some point during their pregnancy and 7-9% drank alcohol throughout their pregnancy (these data excluded the Territories).

Substance Abuse Among Pregnant Women

Concerns about substance use during pregnancy have inspired a plethora of health promotion materials designed to educate pregnant women about their responsibilities toward the fetus. Criticisms of some of these campaigns denote their tendency to reduce alcohol consumption to a lifestyle "choice" being made by the pregnant woman without recognizing the complexity of addiction and the context and relationships that contribute to a woman's behaviour of alcohol abuse (Tait, 2000). Research suggests that the majority of pregnant women misusing substances do not do so because they are unaware of the public health message or because they do not care about the potential harm to their fetus, but rather because they are caught in the grip of an addiction (Tait, 2000).

To date, the emerging field of population health has given minimal reference to the field of addictions (Wiebe, 1997). In turn, addiction specialists have been slow to adopt a framework which gives meaningful recognition to the social context in which the misuse of substances occur (Single, 1999). Reasons for this lack of attention likely stem from a history of ideas around alcohol use/abuse as an individual lifestyle behaviour under the control of personal choice. Moreover, addictions in our society are not seen as value neutral but are instead laden with blame, guilt, stigma and often reproach. A population health framework can serve to illuminate the social forces at work that impact ways in which addictive behaviours are embedded in context and relationships.

It is critical here to establish the importance of examining substance abuse from a gender-specific perspective, in this case, specifically women. After all, research indicates that it is men who drink more alcohol, drink more often, and men's drinking that therefore causes the majority of alcohol associated social harms and uses up more of our health resources (Health Canada, 1995, CCSA/CAMH, 1999). Because alcohol use has historically been seen as a "man's problem", the research around use and abuse, the implementation of programming, and the development of treatment practices have been generated from a male model and perspective, rendering important gender differences invisible and thus under-serving the needs of women who use alcohol (Health Canada, 1995). Until the 1980's, national surveys of drinking and drug use used generic materials and items for both sexes. Most of the questions asked were based on men's experiences with alcohol and may not have always been relevant to women's experiences. Only since the 1980's have research questions more systematically begun to explore gender differences, ask questions more relevant to women's experiences, and therefore more accurately portray substance abuse as it evolves among women (Health Canada, 1995). The patterns that are emerging suggest that there are some important gender related differences to be explored, including but not limited to: reasons for use, usage patterns, outcomes of use (including physiologic effects), social and familial support, effective treatment approaches, and barriers to treatment (Health Canada, 1994,1995, Pagliaro & Pagliaro, 1999, Watson, 1994).

Many of the more apparent differences in drinking patterns between genders relate to the reasons why, and the patterns around, initial use. Through investigating adolescent drinking behaviour, Barber et al (1998) reported that predictors of use include family background, conduct disorder, emotional disorder, having friends who drink, seeking approval from friends and peer pressure. The strength of associations of these factors with use differed between the genders and also throughout age groups. Klaus and Heli (2000) investigated reported positive experiences associated with drinking and also found indications of gender differences with regards to reasons for drinking. In this study women more often reported that they had been able to express their feelings, to sort out interpersonal problems at home or work and that they had felt more optimistic about life. Men more commonly reported that they had been funnier and been able to get closer to the opposite sex.

Research that has aimed to explain substance use and abuse among women has identified a broad and multi-layered array of factors associated with problematic drinking behaviours. These associated factors include: generational effects (genetics); unhappiness/abuse in the childhood home; problematic marriages and other relational problems; personality disorders; sexual identity crises; lack of maternal and family attachment; intelligence; reproductive health; gender role; depression; and age (Pagliaro and Pagliaro, 1999). It thus becomes apparent when compiling and examining such a list, that the underlying causes of these negative health "choices" are embedded in a social context that has broad influence over alcohol use and abuse.

When developing interventions to address the problem of alcohol use by women, there are at least two broad dimensions to be considered. First one must consider that effective treatment for alcohol abuse by an individual woman will need to acknowledge the richness of contextual features that are impacting the choices she makes and the opportunities available to her. Secondly, any attempt to reduce the harmful impact of alcohol use amongst women as a population will need to be implemented with respect to the complex relationships alcohol use has with other determinants of health and the political, systemic, and structural realities which influence the available resources and research agendas for women's health.

Many programs and treatment practices around alcohol abuse have historically been designed and targeted at both genders and often created from a male addiction perspective (Health Canada, 1994). However, what is beginning to become more apparent is that women have particular treatment needs and face particular barriers to accessing treatment. For example, Tait (2000) studied the service needs of pregnant addicted women in Manitoba and found at least four categories of unique needs/ barriers faced by women, including (1) children, (2) social stigma, (3) socio-geographic factors, and (4) the treatment program itself.

As women tend to be primarily responsible for childcare, this can present a unique barrier to accessing treatment. Therfore women prefer treatment programs where childcare services are offered. This is also a reason why women prefer outpatient to inpatient services (Health Canada, 1999). Women express great concern over leaving their children for an extended period, and in many cases they may not have a support person to care for their children if they were to leave. Another concern related to children stems from a mistrust of child service agencies. Some women fear that an admission of alcohol abuse and entering a treatment program will result in their children being taken from them.

There is a tendency in our society to judge those who abuse substances. This point is especially important from a gender perspective as it seems a greater stigma is associated with women's abuse patterns than men's (Health Canada, 1999, Tait, 2000). Pregnant women abusing substances are one of the most stigmatized groups in society, often labeled as "child abusers" or "criminals". For many women it is the fear of this stigma, the loss of their job or the opportunity for future promotions that might prevent them from seeking treatment. Research indicates that drug-dependent women often want help, but that the stereotypes held by society perpetuate the circumstances of their drug use (Miller, 1999).

Socio-geographic barriers represent a whole range of issues such as a lack of programs near to where a woman lives, fear of losing housing if she enters a residential treatment program, lack of money, help and/or options to store personal belongings while entering a residential program, or the inability to take time off work.

Finally with regard to treatment programs, effective treatment for women will have to address the whole woman and the context in which she lives. Women prefer programs that in addition to addiction counseling, also offer vocational skills training and training in assertiveness and parenting skills (Health Canada, 1999). Services that work in conjunction with other specialized services, such as child and sexual abuse counseling, have greater utilization rates (Health Canada, 1999). Many women report that they would be more comfortable in a program that was specifically for women and that there is a shortage of these programs available (Health Canada, 1994, Tait, 2000). Effective, accessible treatment programs for women would necessarily take into account these specific, gender-related barriers and needs.

Population Health Perspectives

This thesis relies heavily on the perspectives and foundations of a population health approach and thus it is important that this backdrop be explained, at least in brief. Population health is a way of thinking about the health of communities and the ways in which people's health is shaped and determined in numerous ways. Population health 1) addresses the health of a population as a whole instead of focusing on the individual, and 2) addresses a range of factors that determine health, well outside the traditional focus on clinical and health service determinants. In Health Canada's 1994 publication "Strategies for Population Health", five broad categories of health determinants are outlined: 1) social and economic environment (including employment, social support networks, education etc.), 2) physical environment, 3) personal health practices, 4) individual capacity and coping skills (including competence, sense of control and self-mastery etc.), and 5) health services. A key component of population health approaches is the recognition that because so many of the factors that influence health fall outside of the traditional health care sector, a crucial aspect of improving the health of a population will rely on "intersectoral action". As described in Health Canada's 1999 publication

"Intersectoral Action: Towards Population Health", intersectoral action calls for those working in varied sectors (i.e. education, justice, environment, health) to join forces, identify shared goals, and work together to address the determinants of health. This action will need to take place both horizontally (across sectors and partners) and vertically (through various policy making domains i.e. federal, provincial, community). These ideologies form the backdrop for the ideas explored in this thesis and the approach taken in that a) health status will be discussed from the perspective of the population rather than the individual and b) health will be discussed using a broad definition of health (inclusive of physical, social and mental well-being), keeping in mind the broader determinants of health, and the ways in which they contribute to, and are affected by issues such as addiction and autonomy.

Legal, Policy, and Public Responses to the Issue

Social Control, Autonomy and Public Health

In their book "Perversion of Autonomy", Gaylin and Jennings (1996) argue that it is to our detriment that western culture has evolved into a "culture of autonomy", where the highest value is seemingly unquestionably placed on autonomy. Their position is that "the culture of autonomy does not permit and cannot adequately justify the means of social control that are necessary to sustain social order and indeed to sustain individual autonomy itself" (pg. 179). They argue, further, that it is too simplistic to create a polarity between autonomy and coercion where autonomy is always good and coercion is always bad (pg. 11). Rather, Gaylin and Jennings point out that "coercion is an essential component of social control and a necessary means of maintaining social order, upon which freedom itself depends." Chapter 9 of this book "In Defense of Social Control" explores the question of "how can coercion be used in a proper, legitimate, morally justified way?"(178). According to Gaylin and Jennings (pg. 180) there are five important factors in the ethical analysis of coercion and social control: (1) agency (who it is that is exercising control over another individual's behaviour), (2) intent (what is the purpose of the control), (3) consequence (the outcome of the act of coercion), (4) means (the type of coercion that is being used), and (5) context (the circumstances in which the coercion takes place).

The authors emphasize that we need to change our habits of moral discourse when it comes to autonomy and coercion. Gaylin and Jennings propose that our automatic condemnation of anything labeled coercive is unjustified and that this "blanket rejection" of anything "coercive" can blind defenders of autonomy to the merits of innovative responses to social problems (pg. 188). Finally, Gaylin and Jennings offer a framework for the ethical evaluation of coercion (pg 189-196): (1) coercion, in and of itself is ethically neutral, (2) coercion must be judged in a particular context, (3) coercion must be judged by its details, and (4) coercion exists along a spectrum of means. Using this approach, the authors argue that there will certainly be instances where coercion is morally justifiable, and in fact that sustaining autonomy in our society *requires* that certain mechanisms of social control, including acts that are coercive, are in place.

Gaylin and Jennings discuss this framework using an example from a pre-natal clinic in South Carolina. From 1989- 1994 this clinic had in place a program whereby pregnant women were tested for cocaine use and if found to be using, were sent to mandatory drug treatment or turned over to the police. The authors conclude that while a "softer approach" might have been more palatable, this form of coercion on pregnant women is defensible and justifiable in order to protect the vulnerable fetus (pg. 196-198).

This issue of drawing boundaries between individual rights and public interest is also taken up the growing lexicon of literature around public health ethics. In their recent article "Public Health Ethics: Mapping the Terrain", Childress at al (2002) point out that this field of public health ethics has different priorities and perspectives than traditional biomedical ethics and that it requires the development of new frameworks and sets of principles. Rather than a focus on the health, well-being, rights etc. of the individual, the field of public health, and therefore public health ethics has at its focus, health, well-being and rights at a population level.

In pursuing their goal of producing a "map of the terrain" of this field, they offer several "general moral considerations" which describe the types of things that a public health ethical analysis should consider. These considerations are:

- Producing benefits
- Avoiding, preventing, and removing harms
- Maximizing the balance of benefits over harms (utility)
- Distributing benefits and burdens fairly (distributive justice) and ensuring public participation (procedural justice)
- Respecting autonomous choices and actions
- Protecting privacy and confidentiality
- Keeping promises and commitments
- Disclosing information, honesty (transparency)
- Building and maintaining trust.

Of course, the problem with lists of general moral considerations is that in any *particular* case, the considerations might conflict, and we require a way to sort out which consideration "wins out". Childress et al. address this issue, particularly with regards to a conflict that often arises in the field of public health. This particular conflict is with regards to promoting good, preventing harms and maximizing utility, versus other commitments such as protecting individual liberty or justice. Here, the authors argue that there are five "justificatory conditions" that can help us determine whether promoting public health in a particular case can override individual liberty (pg. 173). These five conditions are as follows:

1. Effectiveness-it is essential to show that the policy/ act is likely to realize its goal.
2. Proportionality- it must be shown that the public heath benefits will outweigh the infringed general moral consideration
3. Necessity- it should be determined that no better alternatives can be found
4. Least infringement- effort should always be made to minimize the infringement necessary on any of the general moral considerations.
5. Public justification- when public health agents use actions, practices or policies that infringe on one or more general moral considerations, the authors argue, these agents have a responsibility to explain and justify the infringement to all relevant parties.

In the context of mandatory HIV screening, for example, the authors make an interesting distinction between what they call "expressing community" versus "imposing community" (pg. 174). "Imposing community" refers to the use of coercive means to control individual behaviour (e.g., mandatory testing) whereas "expressing community involves taking steps to express solidarity with individuals, protect their interests and gain their trust" (pg. 174). This approach, according to the authors, would attempt to make testing a reasonable and moral choice for individuals and should have priority over imposing community.

In a similar vein as Childress et al., Upshur (2002) focuses on the particular question of when imposing public health interventions is justifiable and outlines four principles to consider. These are the:

1) Harm Principle – which states that public health action which exerts power over a single individual is justifiable only when the purpose is to prevent harm to others, not merely for the individual's own good.
2) Least Restrictive or Coercive Means- dictates that more coercive measures used to control an individual's behaviour are only justifiable when all attempts at less coercive methods have failed.
3) Reciprocity Principle-acknowledged that complying with public health requests may impose a burden upon an individual, thus there is an obligation on behalf of the public health organization to offer assistance to the individual in carrying out their ethical duties.
4) Transparency- finally, this principle refers to the way in which decisions are made and calls for the involvement of all legitimate stakeholders in the decision making process, and that the process be clear and accountable.

Social Control of Pregnant Women Using Substances

In response to the social, economic and health burdens placed on communities by the substance abuse of addicted individuals, society employs a variety of social control mechanisms in an effort to modify or control the behaviour of these individuals. These social control mechanisms may be legal (e.g., criminal sanctions or court-ordered addiction treatment) or non-legal (Wild et al, 2002). As pointed out by Room (1989), those mechanisms falling outside of the legal realm can be further categorized into "formal" and "informal" social control tactics. Formal mechanisms include controlling influences exerted on addicted individuals by agencies or organizations outside of the law, such as social services or employers (as categorized here, these are considered in the non-legal realm since they are not law agencies, even though the coercive tactics undertaken by the formal organization may rest on the threat of applying particular laws or acts). Informal social control mechanisms describe persuasion, threats or other interventions used by family, friends, colleagues etc. used in an attempt to change the behaviour of an individual.

In the case of pregnant substance abusing women, the array of social control mechanisms employed certainly encompass all of these categories.[3] Coercion into substance abuse treatment is one of the most commonly discussed forms of social control. This coercion may occur at the legal realm (e.g., court ordered substance abuse treatment), the formal realm (e.g., threats from social services that a woman's current children, or child on the way may be taken by social services if she doesn't enter a treatment program, see Rutman et al, 2000, pg.18-19), or the informal realm (e.g., threats and pressures issued from family or friends).

Beyond coercion into treatment, alternate strategies have been proposed to address these concerns. In 1997 parliament heard the first reading of Bill C-243- a private members bill that proposed to amend the *Criminal Code* of Canada in order to "make it an offence for a woman who is pregnant to consume a substance harmful to her fetus, unless she definitely intends to abort her fetus". This bill died on the table before a second reading.

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[3] An excellent review of Canadian social policy as it relates to substance abuse and pregnancy can be found in Rutman et al, 2000.

In Alberta in 1998, the case of Jeanette Reid caught attention when she was charged, convicted and sentenced to 6 months in prison under Alberta's *Public Health Act* for sniffing solvents while pregnant. As of 2000 Alberta was the only province to apply public health legislation in this way (Rutman et al, 2000, pg. 16). In February 2001 a National Post story reported that the *Fetal Alcohol Syndrome Society Yukon* was proposing legislation that would make it illegal to sell beer, wine or spirits to pregnant women (Cudmore, 2001).

Other health promotion strategies include examples such as in B.C., where some liquor stores have put up posters depicting five hands covering a glass of alcohol. Four of the hands are adult, while the top hand, a baby's, represents the unborn child. This poster is meant to indicate that the responsibility to reduce drinking during pregnancy rests not only with the expectant mother, but also with those around her (McLean, 2000). In a similar vein in Alberta some restaurants are participating in a "Born Free" program, by which they offer free non-alcoholic beverages to pregnant customers (McLean, 2000).

Selected Relevant Canadian Law

Good reviews of current Canadian law and legal history pertaining to the issue of judicial intervention in pregnancy can be found in Sanda Rogers' "State Intervention in the Lives of Pregnant Women" (1999) and the Royal Commission on New Reproductive Technologies' "Judicial Intervention in Pregnancy and Birth" (Ch. 30, 1993). Three cases that are key for the issues raised in this research are outlined below.

Tremblay v. Daigle. In the 1989 case of Tremblay v. Daigle, heard by the Canadian Supreme Court, Jean Guy Tremblay attempted to prevent Chantal Daigle from aborting a fetus of which he was the father. Tremblay's argument was that the fetus was entitled to protection under the *Quebec Charter of Human Rights and Freedoms* and the *Civil Code of Lower Canada*. The landmark Supreme Court decision however was that the Charter did not apply to the fetus as the fetus is not a *person* until such time as it is *born alive*.

Winnipeg Child and Family Services v. G. (D.F.). The issue of substance abusing pregnant women gained national attention in Canada in 1997 with the case of Winnipeg Child and Family Services v. G. (D.F). In August 1996, Ms. G was 5 months pregnant with her fourth child. She was addicted to glue sniffing, which is extremely dangerous for the development of the nervous system of her unborn child. Ms. G had previously given birth to children who were permanently disabled as a result of her addiction and were wards of the state. Winnipeg Child and Family Services filed a motion to have Ms. G detained in a health centre for treatment until the birth of her baby. At the Manitoba Court trial, Schulman J. ordered that Ms. G. be held in custody by Winnipeg Child and Family Services until the child was born, and also that she undergo prescribed treatment. Here, the Court relied on the Mental Health Act and by extending the *parens patriae* jurisdiction to Ms. G's fetus. Following this decision, and after Ms. G was detained, the detention order was struck down by the Manitoba Court of Appeal. They found no evidence that Ms. G. was incompetent under the Mental Health Act, and also claimed that the *parens patriae* jurisdiction could not be extended in this way. Winnipeg Child and Family Services then appealed this decision to the Supreme Court of Canada which eventually dismissed the appeal stating that:

- The law of Canada does not recognize the unborn child as a legal person possessing rights.
- According to the "born alive rule": only after the child is born, alive and viable, does the law recognize that its existence began before birth (for certain limited purposes). Therefore in this case there was no *legal person* on whose behalf a court order could be made.
- The court's *parens patriae* jurisdiction cannot presently be extended to include unborn children. The potential for this precedent to lead to an infringement of women's rights is great and the matter should be left in the hands of the legislature rather than the courts.

There were two dissenting Supreme Court Justices whose arguments in brief were that:

- Once a woman chooses to carry a fetus to term, she must accept some responsibility for its well-being. Furthermore, the state has an interest in trying to ensure the health of the child.
- The purpose of the *parens patriae* jurisdiction is to do what is necessary to protect the interests of those who are unable to protect themselves. A fetus suffering from its mother's abusive behaviour should fall within this class.
- The born alive rule should be set aside for the purposes of this appeal. This rule is rooted in rudimentary medical knowledge and no longer makes sense to retain it.
- State intervention should be justified in cases where the following criteria are met:
    - The woman has decided to carry the fetus to term
    - It has been established that the woman's abusive activity will cause serious and irreparable harm to the fetus

- The remedy is the least intrusive option
- The process is procedurally fair

In summary, according to this case, Canada has stated that the fetus has no legal rights to personhood, and that the legal system does not have the jurisdiction to intervene in cases where a pregnant woman is abusing substances. Though this provides us with important legal precedent for cases of this particular kind, we are still left with moral questions on *how* to protect *children who will be born* and their mothers at the same time.

Dobson v. Dobson. In New Brunswick, March 14 1993, Cynthia Daigle, who was 27 weeks pregnant at the time was involved in a motor vehicle accident. The fetus she was carrying sustained prenatal injuries and had to be delivered by caesarean section later that day. These injuries resulted in permanent mental and physical impairments to Cynthia's son, Ryan Dobson. Through his litigation guardian, Ryan Dobson brought charges against his mother on the basis that her driving was negligent and thus constituted a "prenatal negligent act". The case was eventually brought to Canada's Supreme Court in 1998 to determine whether in fact "a mother should be held liable in tort for damages to her child resulting from a prenatal negligent act". With two judges dissenting, the decision was made that in fact Ryan Dobson did not have the right to sue his mother for injuries sustained in utero. The justification given for the decision emphasized that the relationship between the mother and fetus is of a truly unique nature, making the case distinguishable from an action for prenatal negligence against a third party.

Public Attitudes Toward Social Control of Substance Users

Goldstein and Buka (1997) conducted a community survey of 720 respondents in three Rhode Island communities to investigate the perceived effectiveness of community-based measures against alcohol misuse. The authors emphasized that a successful community alcohol control strategy requires that it not only demonstrate some empirical efficacy but also that it has a certain degree of public support. The authors note that perceived effectiveness and support for a particular control strategy may be related and yet distinct concepts.

The results of this survey found in general that increased prevention programming in schools, alcoholic beverage server training, and stricter enforcement of drunk driving laws were the strategies most frequently perceived as effective. Those strategies perceived as least effective included stronger warnings on beverage containers, lower legal blood alcohol limits for drivers, and increased alcohol taxation. Importantly, the authors also found that perceptions of effectiveness varied according to the sex and drinking behaviour of the respondent. In general, binge drinking in the last year and male gender were both inversely associated with perceived effectiveness of various social control strategies.

Recent literature has begun to investigate attitudes towards compulsory substance abuse treatment in Canada (Wild et al., 2001). Wild et al. used survey techniques to identify attitudes held towards compulsory substance abuse by the public, substance abuse counselors, probationers, and judges. This research indicated that broad implementation of legislation and policy of this kind would not be uniformly supported across various key stakeholders. Furthermore, judges and the general public were found to be less likely to respect client choice than substance abuse counselors or probationers. To date, there has been little research directed at the specific case of the pregnant substance abusing woman and social attitudes surrounding her treatment. In addition there is a lack of information related to public support for an array of control mechanisms beyond compulsory treatment.

Public Attitudes Toward Social Control of Pregnant Women

Kolder et al. (1987) investigated the scope and the circumstances of obstetrical procedures ordered by the courts on pregnant women who had refused the therapy themselves. Of special interest here is that the authors included in their investigations a survey of the opinions of obstetricians regarding such interventions. They received responses from 57 heads of fellowship programs of maternal-fetal medicine across the country. The authors found that 46% of these obstetricians thought that pregnant women who refused medical advice, thus endangering their fetus, should be detained in order to ensure their compliance. In addition 47% thought that the court precedent of forcing women to have emergency cesarean sections against their will should be extended to include further procedures such as intrauterine transfusions. Some 26% advocated the state surveillance of women in their third trimester who were not in hospital system. Overall the authors found that when taking into account an individual's response to all questions, only 24% of respondents consistently upheld a woman's right to refuse medical advice.

Grabor (1990) described a poll of American Southerners, done through the Atlanta Journal-Constitution, which showed 71% of people supported prosecuting women for taking drugs if it could be shown that it had harmed the baby. Some 45% of respondents were in favour of prosecution for using alcohol and cigarettes and 11% for not eating right or exercising, again if it could be shown that it had harmed the baby.

In a 2002 study, Abel and Kruger surveyed 847 physicians, including obstetricians, pediatricians, and family physicians, in Michigan to determine their attitudes regarding involving the criminal justice system in preventing drug and alcohol abuse during pregnancy. Abel and Kruger (2002) found that 95% of physicians agreed that pregnant women have a *moral duty* to ensure they have healthy babies and 59% agreed they also had a *legal responsibility*. In fact 54% were of the opinion that existing laws concerning child abuse and neglect should be redefined to include alcohol use during pregnancy and 52% were in favour of legislation that would make drug or alcohol abuse during pregnancy to be considered "child abuse" (for the purpose of removing the child from maternal custody). Physicians were *not* however found to be in favour of criminal prosecution for alcohol use during pregnancy. Physicians were in favour of compulsory treatment for alcohol abuse for women already in the criminal justice system.

Concepts of Autonomy

The principle of respect for autonomy is derived from a value of "respect for persons", and has become an integral part in most discussions concerning ethics, human rights, and dignity. This principle of "respect for autonomy" is considered to be of particular importance in the context of health due to the inherent tendency of illness to foster dependency and vulnerability (Sherwin, 1998).

A significant challenge faced in discussions of autonomy is the variety of ways in which it is defined and interpreted. Adding further complexity to this discussion is the fact that immersed in these dialogues around autonomy are varying definitions and conceptions of the nature of the *self*. In order to examine the concept of self-rule or self-governance it is necessary to also explore this question of what comprises the *self*.

V.

This section of the literature review will introduce concepts of autonomy and the "self" spanning from a traditional rationalistic ethical model, to reconceptions from the feminist ethics literature, to alternative perspectives based on theories of human motivation from the psychological literature.

The traditional rationalistic view of autonomy.

Faden and Beauchamp (1986) provide an important and detailed description of a traditional model of autonomy from the bioethics literature. This model of autonomy is further developed and outlined in Beauchamp and Childress' influential *Principles of Biomedical Ethics,* where autonomy is outlined as one of four key "middle level principles" of medical ethics (Beauchamp and Childress, 1994).

In both of these works it is emphasized that in discussions of autonomy, one must first distinguish between the autonomous *person* and an autonomous *action*. These models suggest that although there is no consensus on what the criteria for an autonomous person ought to be, or what constitutes autonomous *action*, there are some generalizations that can be made towards this end, and at least some consensus that having the *capacity* to act autonomously differs from actually *acting* autonomously.

Under the models described (Faden and Beauchamp, 1986, Beauchamp and Childress, 1994), characteristics of an autonomous person may include: capacity for self-governance, understanding, independence, and resistance to control by authorities. An individual who is autonomous is one who is consistent, acts freely in accordance with a self-chosen plan and is the source of his/ her own values and beliefs (in contrast with the notion of values and beliefs that are externally imposed).

As pointed out by Faden and Beauchamp, the problem with demanding definitions such as these is that they are more or less idealistic aspirations of what an autonomous person would be. They tend to be over and above what is generally considered an autonomous person in most contexts. (Faden and Beauchamp, 1986, pg. 236). In order for these descriptions to be less exclusionary, there is a need for a theory that applies to the "normal chooser" (Beauchamp and Childress, 1994, pg. 123).

Both of these works also make it clear that autonomy is not static. An individual may be considered autonomous and capable for making an autonomous decision in one context, while not considered capable in another context or decision-making domain. For this reason it is more helpful to consider context specific decisions and evaluate them as *autonomous actions* (Beauchamp and Childress, 1994 and Faden and Beauchamp, 1986)

The traditional rationalistic model identifies three criteria for autonomous action: intention, understanding, and a lack of controlling influences. Intentional actions are described as actions that are not accidents and are not inadvertent. An intention includes an idea of *how* the act will be done and therefore requires a plan. Intentional actions are those that are "willed in accordance with a plan" (Faden and Beauchamp, 1986, pg.243). Furthermore, in examining intention, Faden and Beauchamp use a model of *willing* rather than *wanting (*Faden and Beauchamp, 1986, pg.246). Though an individual may not directly want the outcome or consequence of a particular action, they are willing to suffer it for some greater good or corresponding outcome. By this standard intentional acts include those that are *tolerated* though they may not be *wanted.*

The condition of understanding refers to an "adequate apprehension of the relevant propositions or statements that correctly describe the 1) nature of the action and

2) the foreseeable consequences" (Faden and Beauchamp, 1986, pg.252). It is important to note that this criterion for autonomous action is not met if an action is based on false beliefs (Faden and Beauchamp, 1986, pg.253).

The third condition of "non-control" is described as not being controlled by external pressures. Three major categories of influence include coercion, manipulation and persuasion. These categories describe the degree to which an individual is being pressured. Under this model, coercion by definition is always controlling, whereas persuasion is not considered to be controlling. Manipulation falls in the middle of this continuum and can be either controlling or non-controlling by degrees (Faden and Beauchamp, 1986).

"Substantial autonomy" refers to the concept that an action can be considered autonomous *to a degree*. How autonomous an action is will depend on how well it meets the three conditions outlined above, and will thus have to be considered contextually (Faden and Beauchamp, 1986). This necessitates setting a threshold level whereby autonomy is considered met (Beauchamp and Childress, 1994).

This model makes the assumption that the condition of intention is one that is either present or not. The other two conditions of understanding and non- control can be met to various degrees and would therefore have to be substantially satisfied in order for the action to be considered "substantially autonomous" as above. (Beauchamp and Childress, 1994 & Faden and Beauchamp, 1986)

In summary then, a substantially autonomous action under this model would be performed with intent, a substantial degree of understanding and a substantial degree of non-control. Where these threshold levels are set will again depend on the context and nature of the decision.

This model also raises the question of authenticity (Faden and Beauchamp, 1986, pg. 262). Are the three conditions described thus far sufficient for autonomous action, or does a condition of authenticity need to be added? Actions that are performed under influences such as drugs or psychiatric conditions are given as examples of actions that, while meeting the first three criteria may not be genuinely autonomous. A further condition of authenticity would necessitate that the action be consistent with the individual's "reflectively accepted values and behaviour" (Faden and Beauchamp, 1986, pg. 263). Faden and Beauchamp conclude that this additional criterion is too demanding in that it is rare for an individual to have systematically and critically reflected and accepted all values employed in most actions and decisions. This limitation would then serve to lessen the range of actions that are deemed worthy of respect under the rubric of *respect for autonomy* (Faden and Beauchamp, 1986, pg. 265).

The authors offer instead a reformulation of the authenticity condition. Instead of a criterion of "reflective acceptance of values", it is modified to *"values and motives are authentic if and only if the agent does not reflectively repudiate or abjure them"* (Faden and Beauchamp, 1986, pg. 267). However this reformulation is also not free of problems and the authors conclude that a more promising approach would be to reformulate the condition of *non-control* to include independence from control in the form of neurotic compulsions, addictions, etc. (Faden and Beauchamp, 1986, pg. 268). This idea has been touched on in the field of law as well in defenses based on alcoholism and addiction (Fingarette, 1983). The argument described is one of involuntariness- that the addicted individual is compelled to use a substance beyond their scope of control and therefore cannot be held responsible for their action.

Beauchamp and Childress concede that an analysis of this more traditional view of autonomy might be critical of the tendency for isolating the individual. The challenge is how to combine the importance of social influence on self-development with the value of feeling like the origin of one's self (Nedelsky, 1989). For example, is there space in this definition of autonomous action for compliance with the authority of state, church or community (Beauchamp and Childress, 1994)? Beauchamp and Childress respond to this with the clarification that autonomy and authority are not incongruent concepts in that an individual can autonomously choose to accept an authority they see as legitimate. Jennifer Nedelsky describes the process as "finding our own law". That is it is not *chosen* but *recognized* and shaped by the society in which we live and the relationships we form (Nedelsky, 1989, pg. 10). Social and cultural settings can thus be a source of moral norms that are then autonomously accepted (Beauchamp and Childress, 1994).

Feminist approaches to autonomy

In the bioethics literature, feminist approaches have been instrumental in defining the self as both independent and *inter*dependent and incorporating social context into discourse around autonomy. Feminist literature incorporates the role of social context and relationships on at least two levels: 1) that external factors influence *who we are,* and 2) that external factors influence whether or not we make decisions and engage in actions that are *consistent with who we are.*

Jennifer Nedelsky stresses the impact that social context has on autonomy in her article "Reconceiving Autonomy" (1989). Nedelsky points out that it is the interaction we have with other people that forms the conceptual framework through which we see the world. She goes so far as to state that "we come into being in a social context that is literally constitutive of us" (Nedelsky, 1989, pg. 8). Nedelsky's argument is that redefining and expanding our concept of autonomy through these reflections is necessary to provide us the language with which to articulate the individual and social dimensions of the self. Her position is that we do not begin life as an autonomous agent; rather it is something we *become*, something we need to *develop* and *sustain.* (Nedelsky, 1989, page 10). She furthermore makes the important link that the "skill" an individual has for engaging in autonomous action can be either developed or constrained by social circumstances. Nedelsky states that it is the support and guidance found in *relationships* that enable us to become autonomous (Nedelsky, 1989, pg.12).

Susan Sherwin proposed an alternative conception of autonomy in her 1998 work "A Relational Approach to Autonomy in Health Care" (Sherwin, 1998). The concept she described, termed "relational autonomy", suggests that much of what constitutes our "selves" and what we value is derived from the relationships we have with others and the social forces at work. Under Sherwin's framework, the experience of the "self" is considered to be an ongoing *process* as opposed to a static identifiable state (Sherwin, 1998, pg.35) and that actions undertaken by individuals are considered within a network of interpersonal and political relationships. Sherwin argues that an inherent problem with more traditional concepts of autonomy is that they place the emphasis on specific decisions being made, as opposed to the social context within which these decisions occur. On her view then, traditional models fail to consider the importance of relationships and policies that affect an individual's ability for engaging in autonomous action (Sherwin, 1998). A relational theory of autonomy can illuminate how oppression diminishes an individual's ability to act autonomously by subverting their sense of being an autonomous agent, as well as interfering with the range of opportunities to make autonomous choices (Sherwin, 1998, pg. 33). Sherwin points out that it is those raised in an atmosphere of privilege and respect that tend to more naturally consider themselves as self governing autonomous beings, compared with those raised behind barriers of oppression. Sherwin's suggestion is that an individual's autonomy skills can be developed through: exercising the skills within a supportive environment, developing a stronger self esteem, and experiencing decision making without controlling influences. She also points out that this process is about more than changing an individual, there is a need to look at expanding the available and acceptable options of choice presented, especially for those groups who have been historically subjugated and oppressed.

Self-hood as a motivated process

It is necessary in this discussion of autonomy and self-determination to elaborate on the nature of the "self". Two dominant perspectives characterized in the psychological literature include a "set of cognitive appraisals and schemata" and a "reflection of social evaluations" (Deci & Ryan, 1990, pg. 237). These perspectives relate to the all-consuming question of who we are. Simply put, the former perspective says we are born into this world, already formed and armed with a uniqueness that is our self. The latter views the self as being formed through the process of relating and interacting with our environment and society.

Deci and Ryan (1990) have conceptionalized the self as a *set of motivational processes*. According to this theory there is an "inherent rudimentary self" that can be termed the "core self". This core self does more than simply reflect social forces at work, it constitutes the *process* through which an individual integrates experiences and actions with a sense of relatedness to others (Ryan, 1993). Similarly Carol Gilligan also refers to a self that is defined by *interaction* as opposed to *reflection* (Gilligan, 1988). Central to this conception of the self are organizational models of self-development, which suggest that development inherently progresses towards increased autonomy and self-regulation (Ryan, 1993). On this view, there is an inherent human tendency toward developing coherency and consistency in one's "self". Deci & Ryan (1990) suggest that this development is intrinsically motivated, and derives from three fundamental needs of the nascent self, including: competence, autonomy and relatedness. Analogous to food, water and shelter for biological growth and well-being, these empirically recognizable needs are the "nutriments" that are requisite for psychological growth and well-being (Ryan, 1995, pg.418).

"Competence" in this model refers to one's need to feel the efficacy of one's actions, an ability to control outcomes and be instrumental in achieving one's desired outcomes. Competence allows one to reliably apply knowledge gained through self-development to new situations and be confident that one can affect change. Autonomy is described as feeling like the origin of one's actions, it implies having an internal locus of causality and being self-regulated (Deci & Ryan, 1990 and Ryan, 1993). The third psychological need identified by Deci & Ryan (1990) is relatedness. Similar to the themes emerging from relational notions of autonomy, relatedness refers to the need to care for and relate to others, to feel a part of the social world.

According to Deci & Ryan (1990), the social context plays a meaningful role in one's behaviour, how one feels and perceives one's self and the course of self–development. Parallel to feminist approaches to autonomy, this theory of the self emphasizes the role that social forces play in supporting or inhibiting self-determination in the development of one's self.

Through the course of development, there is an increasing internalization to the self of values, behaviours, characteristics etc. that started as external forces. Internalization refers to the process of assimilating socially transmitted forms of behaviour regulation that are not inherent in a person's self (Ryan, 1993). This assimilation of regulations into the self is characteristic of a move from heteronomy to autonomy (external regulation to self-regulation). Ryan argues that that this process of integrating external motivations into the self is intrinsically motivated since it is a movement toward an assimilation of the self (Ryan, 1993). Furthermore, environments that are supportive of autonomy facilitate a fuller assimilation of these types of regulations and values (Deci & Ryan, 1990, pg.237). A value or behavioural regulation that is more fully internalized is therefore considered under this model to be more *autonomous*.

According to this motivational psychology framework, self-perception is an integral and ongoing qualification for autonomy and autonomous action. One is only as autonomous as one perceives oneself to be.

The concept of autonomy here relates to the regulations and endorsement of behaviour by the self. Deci and Ryan describe action as being self-determined, controlled or amotivated (Deci & Ryan, 1990). Self-determined and controlled behaviours are both considered intentional, but only self determined behaviour represents a *choice* and would thus be considered autonomous. This description is consistent with the conditions of intention and non-control as described in the Beauchamp and Childress model. Amotivated action describes action whereby an individual is ineffective in its regulation. That is to say that the behaviour is not originating from the "self" and the person is therefore not acting as a true agent. Agency requires action to not only be intentional but also to be characterized by internal perceived locus of causality (Deci & Ryan, 1990). This internal perceived locus of causality refers to the "initiation and organization of behaviour by the self" (Ryan, 1993, pg.13) and corresponds with what Beauchamp and Childress called "authenticity". Phenomenologically, autonomous acts would therefore be those which are *experienced* as freely done and endorsed by the authentic self (Ryan, 1993).

Deci & Ryan (1990) examine the impact of social forces on self-development from three dimensions: autonomy support, structure, and involvement. *Autonomy support* is described as providing an individual with choice, without external pressure and encouraging initiation. The dimension of *structure* is referred to as setting clear expectations, making behaviour outcome contingencies explicit, and providing feedback. Finally, *involvement* is related to the interest and energy put into a relationship by others. The authors state that an environment that is optimal for self-development would be one that supports autonomy, provides moderate structure and contains involved others.

Each of the three models introduced above offers a unique conception and perspective on the nature of autonomy and the self. Through elucidating what each of these models contributes to these concepts, we have a framework within which to discuss, respect, and support autonomy and the autonomous self.

Summary

This review of literature has encompassed several different fields which all have a role to play in the issue tackled by this thesis. First, the nature of the specific public health issue at hand was described, making explicit the harms done by pregnant alcohol using women to their children born with FAS, and indeed to the rest of the community. I then described some key issues related to women's substance abuse including ways in which women's substance abuse needs have been historically underserved and the unique barriers to treatment faced by pregnant alcohol using women. Population health frameworks and ideologies were described, providing an overview of the concepts that form the backdrop for this thesis. The review then moved into explorations of the interplay between autonomy, social control and public health by giving particular attention to the conceptual work of Gaylin and Jennings, Childress et al., and Upshur. These authors take different perspectives on the appropriate role of social control and coercion in society and all offer frameworks designed to help determine the legitimacy of social control in specific instances. I then reviewed various ways in which social control is used to control the behaviour of pregnant substance using women and described some important legal precedents that have been set in Canada on these issues. The review then described some empirical work that has been done already describing public attitudes towards social control of substance abusers and of pregnant women. Finally I explored various perspectives on the nature of autonomy and self were then explored in order to get a clearer picture of the terminology that will be used throughout this thesis and the particular nature of the values at stake.

Chapter 3: An Empirical Study of Public Attitudes Toward Social Control For Pregnant Women who use Alcohol

Overview

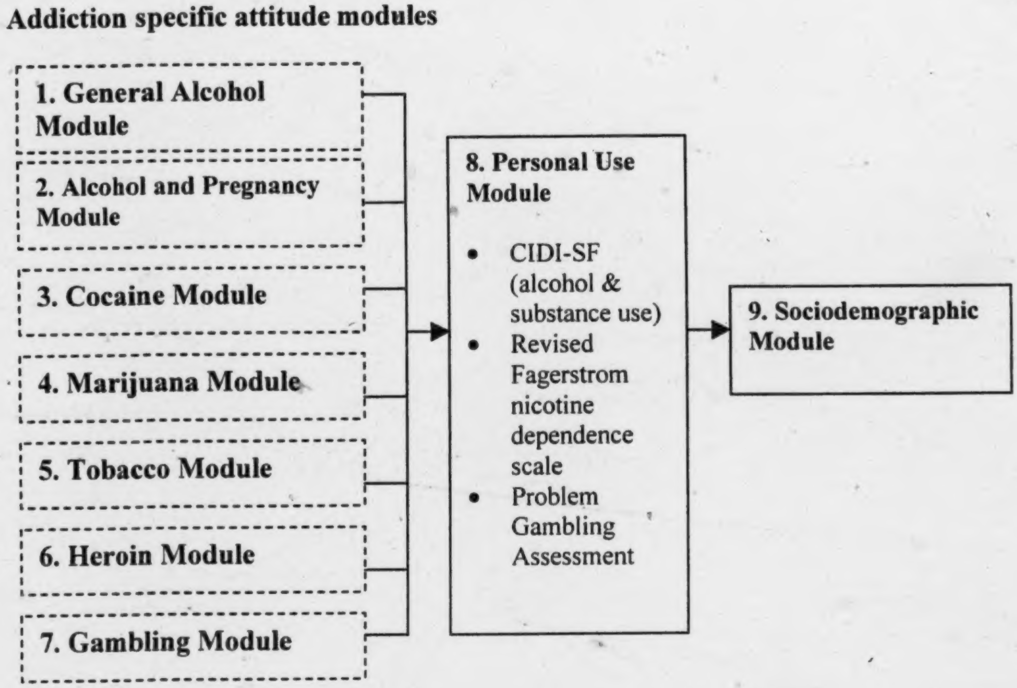
This chapter presents an empirical study describing attitudes of approximately 500 randomly-selected Albertan adults toward a variety of social control mechanisms that could be used to control the behaviour of pregnant women who use alcohol. These data are compared to the attitudes of 500 other adults towards social control tactics for alcohol users in general. As described in Chapter 2, various social control mechanisms have been, and are currently, used in attempts to control the behaviour of pregnant women and ensure healthy pregnancies and children. These range from legal interventions, to coerced treatment, and health promotion and education strategies. Previous studies documenting public attitudes have found substantial public support for the use of coercive social control tactics on those abusing alcohol (Wild et al 2001) and for pregnant women endangering their fetuses (Kolder et al, 1987). Given the public's interest in ensuring healthy birth outcomes, I hypothesized that public attitudes will be more supportive of coercive social control mechanisms towards pregnant women using alcohol than alcohol users in general. In addition, data analysis focused on determining whether differences exist in attitudes towards social control of pregnant alcohol using women across gender, age, and education of respondents. Specifically, I attempted to create a profile of those who are more or less likely to be supportive of coercive practices imposed on pregnant women.

Methods

Survey design

Data described in this chapter were drawn from a larger research project designed to investigate attitudes toward social control and autonomy in substance abuse treatment. This survey was designed to collect attitudes toward the use of social control tactics for each of 7 different possible addictive behaviours (total N = 3500 participants). Respondents were randomly assigned to receive questions associated with one of seven different addictive behaviours. All participants then answered questions pertaining to their personal use and sociodemographic status, as shown in Figure 1.

Figure 1: 7 Addictive Behaviours Survey Flow Chart


Addiction specific attitude modules
1. General Alcohol Module
2. Alcohol and Pregnancy Module
3. Cocaine Module
4. Marijuana Module
5. Tobacco Module
6. Heroin Module
7. Gambling Module
8. Personal Use Module
CIDI-SF (alcohol & substance use)
Revised Fagerstrom nicotine dependence scale
Problem Gambling Assessment
9. Sociodemographic Module

Sample

Participants were randomly selected by generating telephone numbers using random digit dialing techniques. The total sample was stratified into three regions: 1) Edmonton 2) Calgary 3) Other Alberta (includes remainder of Province). For inclusion in this study, respondents had to: 1) be a resident of the telephone number called, 2) be a minimum of 18 years of age and 3) have the next birthday in the household (this technique was used to assure randomness within households).

Data collection

The telephone survey was conducted through the Population Research Laboratory at the University of Alberta. Telephone interviewers and supervisors received training from the Research Coordinator of the Population Research Lab regarding the background of the study and the content of the survey instrument. The interviews were conducted 9:30 a.m. to 9:00 p.m. on weekdays, 10:00 a.m.- 4:00 p.m. on Saturdays and 2:00 p.m.- 8:00 p.m. on Sundays from February to April 2002.

The research lab used CATI (Computer- Assisted Telephone Interviewing) techniques for dialing phone numbers and administering the survey instrument. Each interview began with determining participant eligibility, giving an introduction to the study and obtaining consent to participate (see telephone script, Appendix 1). Once eligibility was assured and the respondent had agreed to participate in the study, the CATI system directed the interviewer to the question series for one of seven randomly assigned topic modules.

A pre-test of the survey instrument was conducted on January 30th, 2002 where a total of 23 respondents were interviewed. The purpose of this was to test the wording of the questionnaire, the appropriateness of the response categories, the length of the survey, and the random module assignment. Following the pretest comments from the interviewers were used to make minor modifications to the survey instrument. After commencement, data collection proceeded until 500 respondents had been interviewed for each of the 7 topic modules.

Measures

Survey items duplicated and extended those used by Wild et al. (2001) in their study of attitudes toward compulsory substance abuse treatment. Questions were designed to be identical across each of the 7 topic modules, differing only in the nature of the addictive behaviour (e.g., "*People* with an alcohol problem should have the final say over whether or not they receive treatment" versus "*Pregnant women* with an alcohol problem should have the final say over whether or not they receive treatment."). Two topic modules were analyzed for this thesis: 1) General Alcohol Module and 2) Pregnancy and Alcohol Module. In addition, data from the Sociodemographic Module was used to describe the samples under study.

Of the 32 questions that comprised the pregnancy and alcohol module of the CATI survey, 21 questions (plus their alcohol module counterparts) were considered directly related to the research objectives of this thesis. These questions are organized into the following five categories: 1) questions that investigate public attitudes toward **public support for autonomy** (e.g., Pregnant women should have the final say over whether or not they receive treatment), 2) questions that investigate public attitudes toward **responsibility versus the disease concept** of alcohol use (e.g., A pregnant woman with alcohol problem is personally responsible for the development of her problem), 3) questions that investigate public views on the **effectiveness** of social control tactics in changing a drinker's behaviour (e.g., The best way to help a pregnant woman with an alcohol problem is to force her into treatment), 4) questions that investigate public attitudes towards the appropriateness of various **means of intervention** (e.g., A pregnant woman with an alcohol problem should be required by law to enter a treatment program), and 5) public **goals and priorities** in treating alcohol users (e.g., Society should make sure that women with drinking problems do not give birth to children with fetal alcohol syndrome, regardless of impact on problem drinker). For complete survey items, see Appendices 2, 3, and 4.

Respondents were asked to give answers corresponding to a 7-category Likert scale indicating the degree to which they agreed or disagreed with the statement (1= strongly disagree, 4= neutral and 7= strongly agree).

Ethical review

Steps were taken to protect the privacy and confidentiality of the study participants and ensure that no foreseeable harms would come to the human research subjects as a result of participation in this research. The survey questions and procedures were approved by the Health Research Ethics Board of the University of Alberta prior to the commencement of data collection. All respondents in this study were required to be over the age of 18. The telephone survey script ensured that each participant was informed: (1) about the purpose of the study, (2) that participation at all points is entirely voluntary, (3) that all answers are confidential, (4) that reports written with these data will not contain information which could be identifiable to the respondent, and (5) of contact information of the survey coordinator they could contact with any questions. The survey administrator confirmed at the beginning of each call that the respondent had heard and understood these terms prior to gaining their verbal consent to proceed with the survey. (See Appendix 1 for complete telephone script for obtaining consent)

Data analysis.

Analysis of the survey data was undertaken using SPSS statistical software. Next, demographic characteristics of the sample were described using frequencies, means, and independent sample t-tests, seeking any significant differences between respondents completing the alcohol vs. alcohol & pregnancy topic modules. In a second set of analyses, mean responses for survey item from the pregnancy and alcohol module were compared to the corresponding mean responses from the alcohol module. In a final step, data analysis focused only on respondents who completed the pregnancy and alcohol module, in order to identify possible gender, age, and educational differences in endorsement of the items.

Results

Characteristics of the study sample

The number of eligible telephone contacts made for the larger study was 6119. Of these contacts, there were 2553 refusals to participate at all and 55 interviews that were not completed, yielding a response rate of 57.4% and a total number of respondents for the study of N=3511.

Respondents completing the alcohol module (n=497) and the alcohol and pregnancy module (n=501) were analyzed, yielding a total N of 998. This sample consisted of 532 females (53.3 %) and 466 males (46.7%). The age ranged from 18 years to 98 years with a mean age of 43.3 years (sd= 16.2). The majority of the respondents

(58.0%) were married and employed at least 30 hours per week (58.4%). 46.2% of the sample had achieved a university or college diploma whereas only 14.2% had less than a high school diploma. The income level among participants was distributed generally evenly. No significant differences were found between the two module groups with respect to 1) gender, 2) age, 3) marital status, 4) employment status, 5) education, or 6) income, suggesting that any differences between attitudes found between the groups cannot be attributed to demographic differences (see Table 1).

Table 1: Demographic Characteristics of Study Sample

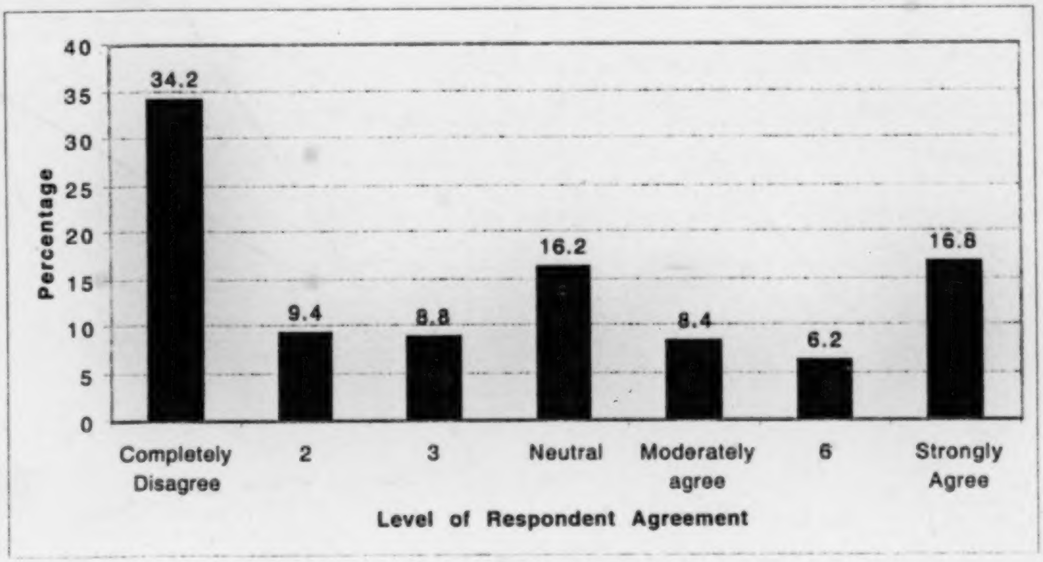
Variable	Module Alcohol (n= 497)	 Alcohol and Pregnancy (n=501)
Gender		
Male	227 (45.7%)	239 (47.7%)
Female	270 (54.3%)	262 (52.3%)
Age	M= 42.95 (sd=16.8)	M=43.7 (sd=15.6)
Marital Status		
Married/Common Law	273 (54.9%)	306 (61%)
Separated/Divorced	54 (10.9%)	50 (10.0%)
Widowed	34 (6.8%)	26 (5.2%)
Single	136 (27.4%)	119 (23.8%)

Variable	Module Alcohol (n= 497)	Alcohol and Pregnancy (n=501)
Employment Status		
Employed 30 hrs/week	283 (56.9%)	300 (59.9%)
Employed<30 hrs/week	46 (9.3%)	48 (9.6%)
Unemployed	18 (3.6%)	12 (2.4%)
Student	40 (8%)	31 (6.2%)
Homemaker	32 (6.4%)	38 (7.6%)
Retired	67 (13.5%)	65 (13.0%)
Disabled	10 (2.0%)	7 (1.4%)
Highest level of education		
Grade 9 or less	21 (4.2%)	32 (6.4%)
Some high school	44 (8.9%)	44 (8.8%)
High school diploma	103 (20.7%)	97 (19.4%)
Some post secondary	111 (22.3%)	84 (16.8%)
Post secondary degree/diploma	218 (43.9%)	242 (48.3%)
Income		
Under $20,000	66 (13.3%)	64 (12.8%)
$20,000-$29,0000	52 (10.5%)	55 (11.0%)
$30,000-$39,0000	54 (10.9%)	60 (12.0%)
$40,000-$49,0000	55 (11.1%)	50 (10.0%)
$50,000-$59,0000	41 (8.2%)	51 (10.2%)
$60,000-$69,0000	36 (7.2%)	32 (6.4%)
$70,000-$79,0000	27 (5.4%)	33 (6.6%)
$80,000-$89,0000	27 (5.4%)	16 (3.2%)
$90,000-$99,0000	16 (3.2%)	20 (4.0%)
$100,000 or more	65 (13.15)	62 (12.4%)

Analyses Comparing General Alcohol Items to Pregnancy and Alcohol Items

Public support for autonomy: Perhaps the most fundamental question of autonomy, as it pertains to the issue of alcohol use and pregnancy, is addressed in question one, the basic question of whether or not *women who are pregnant should be able to decide for themselves whether or not they will consume alcohol.* This question, the first in the series asked of participants receiving module two, was unique in that it did not frame the behaviour in the context of an "alcohol problem" and did not have a corresponding alcohol module question counterpart. As shown in Figure 2, the majority of respondents disagreed with this statement (52.4%). In fact 34.2% of respondents "strongly disagreed" that pregnant women should decide for themselves whether or not they consume alcohol. Some 16.2% of respondents were "neutral", leaving only 31.4% that were in agreement.

Figure 2: Should Pregnant Women be Allowed to Decide for Themselves Whether or not to Consume Alcohol?



As shown in Table 2, there were several differences between respondents' attitudes toward pregnant women who drink alcohol versus people in general who drink alcohol. Specifically, respondents were less likely to agree with statements that pregnant alcohol users *should have the final say over whether or not they receive treatment* (M=2.87), that they *should be able to decide for themselves whether or not to enter treatment* (M=3.49), and that they *should be free to drink anywhere they want* (M=2.62), compared to alcohol users in general (Ms=4.08, 4.47, & 2.96, ps<0.05). In fact, 65% of survey respondents disagreed that pregnant women drinking alcohol should have the final say over whether or not they receive treatment, compared to just 39% who disagreed that alcohol users in general should have this "final say".

Table 2: Mean Attitude Scores for Items on Autonomy

Variable	Means by module		
	Alcohol	Pregnancy and Alcohol	t
1. ______ should have the final say over whether or not they receive treatment	4.08	2.87	9.25*
2. ______ should be allowed to decide for themselves whether or not they go into treatment for an alcohol problem	4.47	3.49	7.76*
3. ______ should be free to accept or reject treatment	2.36	3.04	-5.54*
4. ______ should not be able to drink anywhere they want	4.56	4.81	ns
5. ______ should be free to drink anywhere they want	2.96	2.62	2.70*

Note: Responses coded from 1-7, 1= strongly disagree, 4= neutral, 7=strongly agree. "______" refers to "person/people" for alcohol module and "pregnant woman/pregnant women" for the pregnancy and alcohol module. * difference is significant at $p<0.05$. Degrees of freedom for t-test range from 972-991 because of missing data

Responsibility/ disease concept. In examining responses to questions pertaining to the disease concept and responsibility of alcohol use, it was found that respondents generally agreed that the responsibility for both the development of the alcohol problem and for changing the behaviour lie with the alcohol user, with no significant difference whether it be an alcohol user in general or a pregnant woman (refer to Table 3). However respondents were significantly more likely to agree that alcohol use by pregnant women was a "disease" and that the pregnant woman would require outside help in order to change her behaviour (M= 5.20) compared to alcohol users in general (M= 4.71, p<0.001).

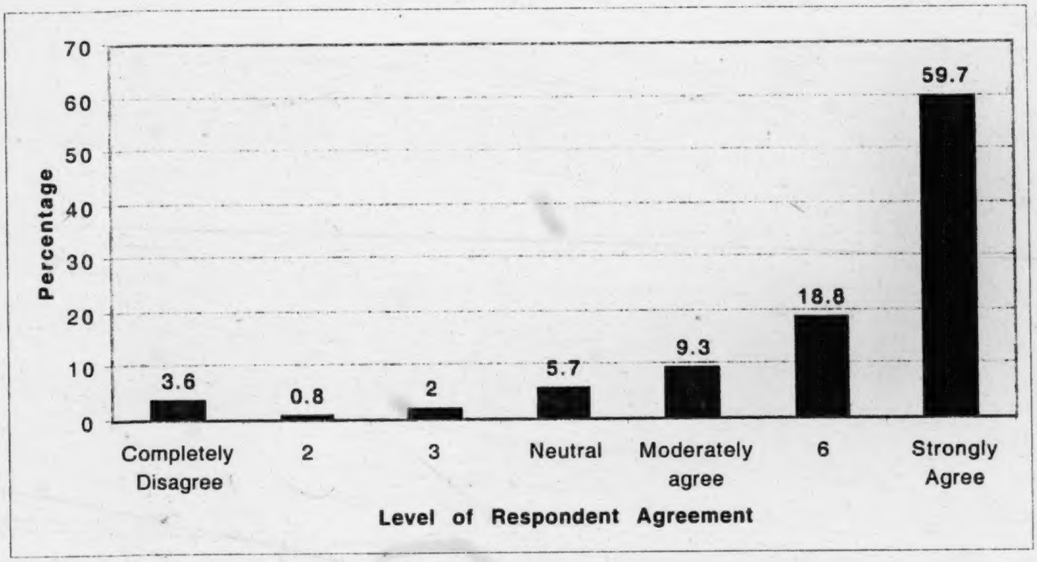
Table 3: Mean Attitude Scores for Items on Responsibility/ Disease Concept

Variable	Means by module		t
	Alcohol	Pregnancy and Alcohol	
1. ______ with an alcohol problem is personally responsible for the development of his or her problem	5.08	5.24	ns
2. _______ with an alcohol problem is personally responsible for changing his/her behaviour	5.59	5.40	ns
3. _______ with an alcohol problem has a disease and cannot change their behaviour without outside help	4.71	5.20	-4.01*

Note: Responses coded from 1-7, 1= strongly disagree, 4= neutral, 7=strongly agree. "______" refers to "person/people" for alcohol module and "pregnant woman/pregnant women" for the pregnancy and alcohol module. * difference is significant at p<0.05. Degrees of freedom for t-test range from 982-998 because of missing data

In addition respondents generally quite strongly agreed that pregnant women are personally responsible for any damage caused to the fetus by alcohol (M=6.12). In fact 87.9% of respondents were in agreement with this statement, 5.7% were neutral and only 6.5% disagreed (refer to Figure 3).

Figure 3: Are Women Personally Responsible for Damage to the Fetus Caused by Alcohol?



Perceived effectiveness of social control strategies. As shown in Table 4, attitudes toward effectiveness of intervention were interesting in that respondents disagreed in general for both modules that the *best way to help someone with an alcohol problem was to "force" them into treatment*, however they were significantly more likely to agree with the effectiveness of this strategy in the case of pregnant women (M= 3.85) compared to alcohol users in general (M= 3.05, $p<0.001$). In both modules respondents agreed that trying to change someone's drinking habits would be ineffective without addressing environmental issues as well.

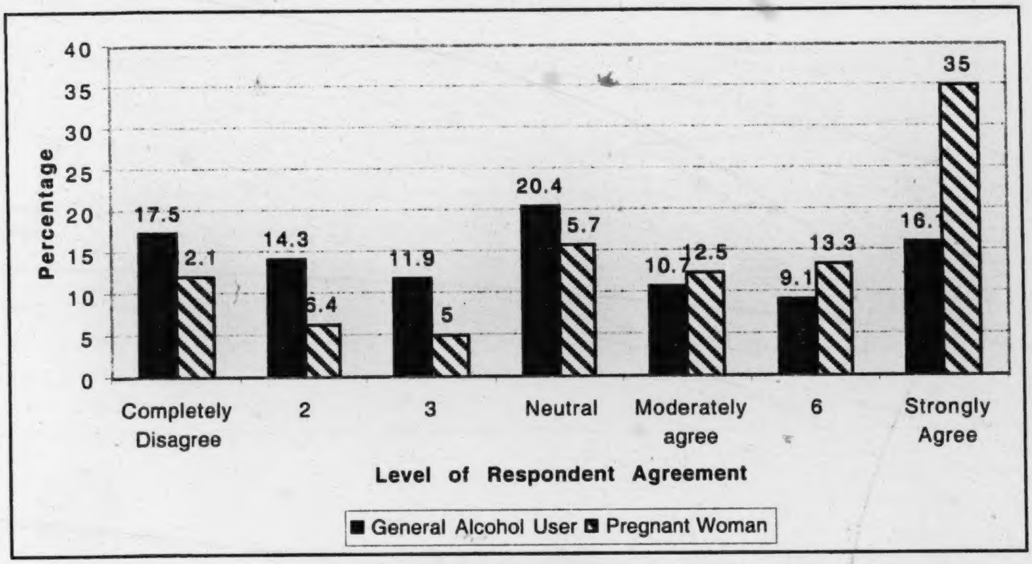
Table 4: Mean Attitude Scores for Items on Effectiveness

Variable	Means by module		t
	Alcohol	Pregnancy and Alcohol	
1. best way to help ______ with an alcohol problem is to force him/her into treatment	3.05	3.85	-6.02*
2. trying to change a______'s drinking habits is a waste of time unless you change their environment	4.27	4.22	ns

Note: Responses coded from 1-7, 1= strongly disagree, 4= neutral, 7=strongly agree. "______" refers to "person/people" for alcohol module and "pregnant woman/pregnant women" for the pregnancy and alcohol module. * difference is significant at $p<0.05$. Degrees of freedom for t-test range from 978-998 because of missing data

Support for different means of intervention. Respondents were more supportive of imposing social control mechanisms on pregnant women using alcohol versus alcohol users in general (see Table 5). Specifically, respondents were less likely to agree that general alcohol users *should be required by law to enter treatment programs* (M=3.84), compared to pregnant women (M= 4.90, $p<0.001$). In fact only 36% of respondents felt that legal intervention was appropriate for the general alcohol user (20% were neutral) compared to 61% of respondents who agreed it was appropriate for pregnant women using alcohol (16% were neutral) (refer to Figure 4).

Figure 4: Support for Legal Intervention for Alcohol Users



In addition, with regards to informal social control mechanisms, respondents were more likely to agree that they would try to convince a pregnant woman *to cut down or stop drinking* (M=6.52) and that they *would arrange for her to enter a treatment program* (M=4.91), compared to alcohol users in general (Ms=6.25 & 4.27, ps<0.01). Correspondingly, respondents were less likely to agree that *it would be wrong to convince a pregnant woman to cut down or stop drinking* (M=1.76) or *wrong to arrange for her to enter a treatment program* (M=2.22), compared to alcohol users in general (Ms=2.24 & 2.75, (ps<0.001).

When it came to using threats however, the most coercive of the informal social control mechanisms inquired about, respondents generally disagreed that that they would threaten either an alcohol user in general (M= 2.28) or a pregnant woman (M= 2.28) to get them to stop drinking. In general respondents agreed that threatening someone in this way would be wrong, both in the case of the alcohol user (M= 5.17) and the pregnant woman (M= 5.32).

In summary, for both modules respondents were less likely to agree they would undertake the action as the level of coerciveness rose, and more likely to agree that the action was "wrong". Respondents were significantly more supportive of using social control mechanisms on pregnant women using alcohol than alcohol users in general.

Table 5: Mean Attitude Scores for Items on Means of Intervention

	Means by module		
Variable	Alcohol	Pregnancy and Alcohol	t
1. ______ who has an alcohol problem should be required by law to enter a treatment program	3.84	4.90	-8.06*
2. If I knew ______ had an alcohol problem, I would try to convince them to cut down or stop drinking	6.25	6.52	-3.32*
3. I think it would be wrong to try to convince a_______ with an alcohol problem to cut down or stop drinking	2.24	1.76	4.65*
4. If I knew a ______who had an alcohol problem, I would arrange for them to enter a treatment program	4.27	4.91	-5.20*
5. I think it would be wrong to arrange for a ______ with an alcohol problem to enter a treatment program	2.75	2.22	4.56*

Variable	Means by module		t
	Alcohol	Pregnancy and Alcohol	
6. If I knew a _______ who had an alcohol problem, I would threaten them in order to get them to cut down or stop drinking.	2.28	2.28	ns
7. I think it would be wrong to threaten a _______ with an alcohol problem to get them to cut down or stop drinking	5.17	5.32	ns

Note: Responses coded from 1-7, 1= strongly disagree, 4= neutral, 7=strongly agree. "______" refers to "person/people" for alcohol module and "pregnant woman/pregnant women" for the pregnancy and alcohol module. * difference is significant at $p<0.05$. Degrees of freedom for t-test range from 978-998 because of missing data

Public goals and priorities. With regards to public goals and priorities, the results are unclear (refer to Table 6). Respondents did not seem to prioritize either the substance abuser or those affected by their use, and generally agreed for both modules that that helping both parties (both fetus and family and friends of alcohol user) would be a priority.

Table 6: Mean Attitude Scores for Questions on Public Goals/Priorities

Variable	Means by module		
	Alcohol	Pregnancy and Alcohol	t
1. Society should do everything possible to help a ________ with drinking problems, regardless of impact on family and friends/ fetus	4.73	5.24	-4.36*
2. Society should do everything possible to help family and friends affected by problem drinkers/ Society should make sure that women with drinking problems do not give birth to children with fetal alcohol syndrome, regardless of impact on problem drinker	5.34	5.07	2.52*

Note: Responses coded from 1-7, 1= strongly disagree, 4= neutral, 7=strongly agree. "______" refers to "person/people" for alcohol module and "pregnant woman/pregnant women" for the pregnancy and alcohol module. * difference is significant at $p<0.05$. Degrees of freedom for t-test range from 954-971 because of missing data

Analysis of Sub-group Differences for Pregnancy and Alcohol Module Only

Gender Differences. Table 7 shows significant differences that were found when mean responses were compared between male and female respondents of the alcohol and pregnancy module using t-tests. Results of this gender analysis revealed four questions where significant differences existed. Female respondents were more likely to agree that *a pregnant woman is personally responsible for any FAS shown after the child is born*

(M= 6.25), compared to males (M= 5.97, p<0.05). Similarly, women were more likely to agree that *a pregnant woman has a disease and cannot change her behaviour with outside help* (M= 5.49) as compared to men (M= 4.89, p<0.001). In the category of questions regarding means of intervention, only one question was found to have significant differences in responses between males and females. Here, women were more likely to agree that *pregnant women using alcohol should be required by law to enter a treatment program* (M= 5.18) as compared to men (M= 4.60, p<0.01). Likewise only one question under the category of autonomy showed significant differences between gender, where women were more likely to disagree that *pregnant women with an alcohol problem should be free to drink wherever they want* (M= 2.44) as compared to men (M= 2. 82, p<0.05). No differences between responses from men and women were found in questions pertaining to either effectiveness or public priorities/goals.

Table 7: Differences in Attitudes Towards Social Control of Pregnant Women Using Alcohol by Gender

Variable	Means by gender		
	Males	Females	t
1. A pregnant woman should be free to drink anywhere she wants	2.82	2.44	2.10*
2. A pregnant woman with a drinking problem is personally responsible for any damage caused to the fetus by alcohol	5.97	6.25	-2.11*
3. A pregnant woman with a drinking problem has a disease and cannot change her behaviour without outside help	4.89	5.49	-3.61*
4. A pregnant woman with a drinking problem should be required by law to enter a treatment program	4.60	5.18	-3.11*

Note: Responses coded from 1-7, 1= strongly disagree, 4= neutral, 7=strongly agree. difference is significant at $p<0.05$. Degrees of freedom for t-test range from 486-498 because of missing data.

Age. Analyses of variance were conducted to determine whether respondents of different ages held different attitudes about imposing social control mechanisms on pregnant women. Ages of respondents were categorized into young adults (18-24), adults (25-64), and seniors (>=65), in accordance with age categories used by Statistics Canada. Tukey post hoc comparison procedures were then used to determine where differences existed between groups. As shown in Table 8, these analyses showed significant effects of age on five questions. Analysis showed a significant effect of age on respondent's willingness to try to convince a pregnant woman to cut down or stop drinking (F[2, 495]=

4.12, p<0.05), such that young adults (M= 6.7) and adults (M= 6.6) were both more likely to agree that they would *try to convince a pregnant woman to cut down or stop drinking* as compared to seniors (M= 6.1, p<0.05 and p<0.05). Results also showed a significant effect of age on respondent's belief that it would be wrong to try to convince a pregnant woman to cut down or stop drinking (F[2, 495]= 15.11, p<0.001). Young adults (M= 1.6) and adults (M= 1.6) were both more likely to disagree that *it would be wrong to try to convince a pregnant woman to cut down or stop drinking* as compared to seniors (M= 2.8, ps<0.001).

Finally, results showed a significant effect of age on respondent's willingness to arrange treatment for a pregnant woman with an alcohol problem (F[2, 488]= 4.02, p<0.05). Adults (M= 4.8) and seniors (M= 4.7) were both less likely to agree that they *would arrange treatment for a pregnant woman with an alcohol problem* as compared to young adults (M= 5.5, ps<0.05).

Within the category of *autonomy*, results showed age had a significant effect on participant's belief that pregnant women should be allowed to decide for themselves whether or not to consume alcohol (F[2,496]= 3.58, p<0.05). Young adults were more likely to disagree that *pregnant women should be allowed to decide for themselves whether or not to consume alcohol* (M= 2.7), as compared to adults (M= 3.5, p<0.05).

Finally, within the category of *effectiveness*, one question was found to have significantly different responses with respect to age. Age was found to have an effect on participants belief that changing a pregnant woman's behaviour would be dependent on changing her environment (F[2, 489]= 3.64, p<0.05). Seniors were more likely to agree that *trying to change a pregnant woman's drinking habits is a waste of time unless you change her environment (*M=4.7), as compared to adults (M= 4.1, p<0.7)

With respect to age, no significant differences in responses were found in questions within the categories of *responsibility* or *public goals/priorities*.

Table 8: Differences in Attitudes Towards Social Control of Pregnant Women Using Alcohol by Age

Variable	Means by age category			
	Young adult	Adult	Senior	F
1. A pregnant woman with a drinking problem should be allowed to decide for herself whether or not she consumes alcohol	2.7_a	3.5_b	3.4_{ab}	3.58*
2. Trying to change a pregnant woman with a drinking problem's drinking habits is a waste of time unless you change her environment	4.6_{ab}	4.1_a	4.7_b	3.64*
3. If I knew a pregnant woman with a drinking problem, I would try to convince her to cut down or stop drinking	6.7_a	6.6_a	6.1_b	4.12*
4. I think it would be wrong to try to convince a pregnant woman with a drinking problem to cut down or stop drinking	1.6_a	1.6_a	2.8_b	15.11*

Variable	Means by age category			F
	Young adult	Adult	Senior	
5. If I knew a pregnant woman with a drinking problem, I would arrange for her to enter a treatment program	5.5_a	4.8_b	4.7_b	4.02*

Note:
difference is significant at $p<0.05$. Means in the same row with subscripts not sharing the same letter differ from each other at significance of $p<0.5$, using Tukey's post hoc comparison procedures.

Education. Analyses of variance were also conducted to determine whether respondents of different levels of education held different attitudes about social control mechanisms and pregnant women with regards to drinking alcohol. Respondents were categorized into three categories indicating the highest level of formal education they had received: 1) less than high school diploma, 2) high school diploma, and 3) (at least some) post secondary education. Tukey post hoc comparison procedures were also used to determine where differences existed between groups. As shown in Table 9, these analyses showed significant effects of education on responses to three questions.

Within the category of *autonomy*, analysis showed a significant effect of education on respondent's belief that pregnant women should not be able to drink wherever they want.($F[2, 486]= 2.94$, $p=0.05$). Respondents with at least some post secondary education were less likely to agree that *pregnant women with an alcohol problem should not be able to drink wherever they want* ($M=4.7$) as compared to those with just a high school diploma ($M= 4.9$, $p<0.05$).

Likewise, analysis showed a significant effect of education on respondent's belief that pregnant women should be free to drink wherever they want (F[2, 483]= 4.02, $p<0.05$). Respondents with a high school diploma were more likely to disagree that *pregnant women with an alcohol problem should be free to drink wherever they want* (M=2.1) as compared to those with at least some post secondary education (M= 2.8, $p<0.05$).

Within the category of *means of intervention*, analysis showed a significant effect of education on respondent's willingness to use threats to control the behaviour of pregnant women (F[2, 491]= 4.16, $p<0.05$). Respondents with at least some post secondary education were more likely to disagree that they *would threaten a pregnant woman in order to get her to cut down or stop drinking* (M=2.1) as compared to those respondents with less than a high school diploma (M= 2.6, $p<0.07$).

With respect to level of education, no significant differences in responses were found in questions within the categories of *responsibility*, *effectiveness* or *public goals/priorities*.

Table 9: Differences in Attitudes Towards Social Control of Pregnant Women Using Alcohol by Education

Variable	Means by education level			F
	< high school	high school	post secondary	
1. A pregnant woman with a drinking problem should not be able to drink anywhere she wants	4.9_{ab}	5.2_{a}	4.7_{b}	2.94*
2. A pregnant woman with a drinking problem should be free to drink anywhere she wants	2.6_{ab}	2.1_{a}	2.8_{b}	4.02*
3. If I knew a pregnant woman with a drinking problem, I would threaten her in order to get her to cut down or stop drinking.	2.6_{a}	2.6_{b}	2.1_{b}	4.16*

Note:
* difference is significant at $p<0.05$. Means in the same row with subscripts not sharing the same letter differ from each other at significance of $p<0.5$, using Tukey's post hoc comparison procedures.

Discussion

Overview of key findings

Results clearly show that Albertans in general find that some social control mechanisms are justified to protect unborn fetuses from alcohol ingested by pregnant women. The fact that only 31.4% of Albertans feel pregnant women should be able to decide for themselves whether or not they consume alcohol speaks volumes about the importance society feels about protecting a fetus from damage in utero. One would presume that most people feel adults in general have the right to decide whether or not they consume alcohol- indicating that the general perception is that somehow a woman's decision-making authority changes once she becomes pregnant. Similarly, significant differences were found in attitudes surrounding a pregnant woman's right to decide whether or not to enter a treatment program, her right to accept or reject treatment and where she should be allowed to drink.

Thus it becomes is clear that the Alberta public believes that decision-making authority, and the right to autonomy, of the pregnant woman is somehow *different*. The nature of this *difference* might be explained in various ways. For example, perhaps people in general feel that the fetus does in fact have rights to a safe environment that could legitimately compete with the rights of the mothers to make decisions, engage in risky behaviours etc. Or perhaps people in general feel that when a woman decides to carry a fetus to term, she in some way *relinquishes* her right to complete autonomy with regards to her body and associated health behaviours or medical interventions.

This study provides empirical evidence of a concern and belief long held in feminist writings and discourse regarding women's reproductive roles: that the state of pregnancy is generally believed to diminish the rights and freedoms generally afforded to women.

When considering how a pregnant woman is perceived and judged in the context of alcohol problems, it appears that Albertans consider the development their alcohol problem, and the change in their behaviour to be the sole responsibility of the drinker, whether she is pregnant or not. Given this, it still appears that the public is much more likely to see the pregnant woman as having a *disease* and in *need of* social intervention in order to change. There are at least two possible explanations for these results. The first has to do with the stigma and negative emotion that is inspired by a pregnant woman's alcohol use. It is feasible that when the public thinks of a pregnant woman drinking alcohol, her behaviour is seen with such abhorrence that most people think her behaviour must be the result of a "disease". On this view, her behaviour may be contrary to what any rational healthy person would do, and thus this individual is sick and therefore in need of outside assistance. A second explanation follows from the idea that the public is much more concerned about the pregnant drinker, given the known effects on the child who will be born (usually seen as an innocent and helpless being) and therefore there is a much wider spread desire to change the behaviour of these women, compared to alcohol users. Given this extra motivation to change the behaviour of pregnant women, the public may be in fact justifying whatever means they think might be necessary by holding fast to the idea that the woman's alcohol use is due to a "disease" and that these women are in need of assistance.

This second explanation can also be applied when looking at responses about the question of effectiveness of mandatory treatment. Albertans were more likely to agree that forced treatment was the best way to help a pregnant alcohol user versus an alcohol user in general. However the question remains whether or not this is necessarily reflective of a belief that forced alcohol treatment will actually be more effective for a pregnant woman, or rather a reflection of the public's need to justify why forced treatment should be a viable option for dealing with the problem of a pregnant woman's alcohol use? An argument for the former might be that people tend to believe that pregnant women will feel a stronger motivation to change her behaviour than most alcohol users, and thus will give additional effort to a treatment program even if her initial entry into treatment was coerced in some manner.

Previous case examples (e.g., Winnipeg v. D.G.) highlighted the question of whether or not the law should be used to intervene in controlling the drinking habits of pregnant women. This study clearly documents that, at least in Alberta, there would be some support for this type of legislation.

Perhaps unsurprisingly, the survey results show that support for various informal social control mechanisms decreases as the level of coerciveness increases. More interesting is the overall findings from this study that public support for imposing social control tactics on pregnant women is indeed more widespread than for alcohol users in general. This idea that society is more concerned, and more apt to seek ways of changing the behaviour of a pregnant woman using alcohol versus an alcohol user in general, is not new, nor is it counterintuitive in any way; however this study provides the evidence to support such intuitions and also some measure of the extent of the attitudinal shift.

Gender analysis of these data revealed findings that might be considered a surprising form of gender bias. Compared to male respondents, women were found to be more supportive of limiting pregnant women's freedom, imposing formal social control mechanisms on pregnant women and placing full responsibility for fetal alcohol syndrome on pregnant women. There are several explanations to consider for these results. One possibility is a "backlash" of sorts that many males might feel with regards to women's rights issues. That is, men might feel more reluctant to make statements or hold beliefs that might be considered as limiting to women's rights and freedoms. Political correctness and sensitization to marginalized populations (at least in public discourse) can be quite powerful influencing forces shaping public responses to issues. Another explanation might be that women simply feel stronger about controlling other women's behaviour in order to protect a developing fetus (e.g., arising from a "maternal instinct") and are less concerned with restrictions on women's autonomy than with providing a child the healthiest possible environment before birth. That is to say that women have an innate sense of the moral responsibility and seriousness of undertaking a pregnancy. Yet another consideration is the possible "backlash" that women in general might feel if they were to assert to strongly their right of autonomy "over" the consideration of a healthy child. Further investigation is required to get a true sense of the reasons for these attitudinal differences between genders.

Age analysis of attitudes surrounding social control of pregnant substance abusing women revealed an interesting pattern. Results showed that, in general, younger generations were more likely to be supportive of various social control interventions than older generations and less likely to support a pregnant woman's right to choose whether or not to consume alcohol. This pattern is interesting in that it is perhaps counter-intuitive given the cultural phenomenon of an ever increasing emphasis placed on autonomy in Western bioethics and prevailing societal norms. There are several possible explanations for this result. For example, knowledge about the harmful effects of alcohol in utero and diagnoses of FAS/FAE only began to surface in the 1970's, earlier than the average childbearing years of the "seniors" of this respondent group. It is possible therefore that youth and adults have been exposed to much more information, and hold a deeper awareness of the potential dangers of alcohol use during pregnancy (including the negative impact on society in general) and are thus more apt to want to control this behaviour.

Another explanation of this trend might be a sort of "etiquette" or "propriety", held by older generations, which would make it less acceptable to intervene in the lives of others. The youth of today are perhaps much more accustomed to a culture where numerous formal social control mechanisms are in place to control the behaviour of individuals.[4] As with the pattern noticed with gender analysis, further investigation explicitly addressing a richer exploration with these demographic groups would be needed to ascertain the source of these attitudinal differences between groups.

The most interesting result of the education analysis was with regards to threatening a pregnant woman with an alcohol problem to enter a treatment program. This intervention was the most coercive of the informal mechanisms of social control inquired about. Results showed that supportive attitudes of this tactic decreased with increasing level of education. This pattern might be indicative of an increasing appreciation for concepts such as autonomy and theories of self-motivation, with increasing exposure to formal education. For example those with post secondary education conceivably have had more opportunity to explore the ideas of psychology, philosophy, and ethics. In addition post-secondary education tends to focus on developing critical thinking skills such that this subgroup of participants might be more likely to consider a variety of far reaching consequences to implementing coercive social control tactics and better able to identify less coercive alternatives.

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[4] The assumption here is that given ongoing cultural and social shifts that occur over time, individuals who grew up for example in the 1970's would have been exposed to different political climates, social norms, etc. than individuals growing up in the 1940's.

Limitations

It is important here to point out several limitations of the study at hand. First of all the survey provided only a basic description of attitudes toward social control and beliefs, as a first step in understanding. Because these concepts, the attitudes surrounding them, and the values behind them, are quite intricate, a richer exploration would likely require a more qualitative study design to gain a deeper understanding of the attitudes people hold on these issues. Another limitation is that the nature of the questions asked allowed for different interpretations by study respondents. For example the study used the phrase "people with an alcohol problem" and "pregnant women with an alcohol problem". The advantage of this phrasing is that it avoids concerns with the varying definitions within the addiction literature on what exactly constitutes alcoholism, substance abuse, substance misuse, substance dependence etc. However, the disadvantage is that each respondent will have thus subjectively interpreted what they consider "an alcohol problem", leaving room for variance in their replies. For example, responses may have been different had the questions been phrased using terms as "an alcoholic/ a pregnant alcoholic" or "a heavy drinker/ a pregnant heavy drinker".

In summary, this study gives us an empirical "snapshot" of prevailing attitudes surrounding social control of alcohol using pregnant women and how these differ from attitudes surrounding social control of alcohol users in general. This information is helpful in answering the descriptive ethical question of "what values *do* guide our actions with regards to imposing social control mechanisms on pregnant women versus alcohol?"

before tackling the normative ethical question of "what values *ought to* guide our actions with regards to imposing social control mechanisms on pregnant women versus alcohol?", which I will explore in Chapter 4 of this thesis.

Results of this study have given empirical support to the intuitive sense that the public does in fact feel a responsibility and duty to manage the behaviour of pregnant women such that unborn children are protected from potentially damaging effects. Furthermore I found that that most people feel that a pregnant woman's decision making authority is somewhat lessened from that of someone not carrying a fetus and that both societal structures (such as the law) and interpersonal relations have more of a right to control her decisions.

Further research is needed in this area to gain a better and more nuanced understanding of the attitudes held by society on this issue, how individuals came to have these attitudes, and, perhaps most importantly, the values behind these attitudes. These questions would likely be most effectively addressed by qualitative work designed to build on the empirical data presented here.

Chapter 4: An Ethical Analysis of Social Control for Pregnant Women who use Alcohol

Introduction

Given the tragic consequences that can result from alcohol use by pregnant women, it seems intuitive that society has an interest in ensuring that women make healthy choices during pregnancy, so as to protect the developing fetus. However the very location of a fetus *inside* a woman brings important moral questions to bear, including micro-level considerations such as encroachments on a woman's autonomy or the maternal-fetus relationship, as well as broader macro-level considerations such as the ways in which women have been historically subjugated as a whole, or what the appropriate role of society in protecting the fetus ought to be.

Previous literature has highlighted the emerging policy context which is supportive of using legal mandates for compulsory treatment in response to the social problem of substance abuse (Wild, 1999, Wild et al. 2002). This trend is reflected in an increasing number of "drug courts" and mandates in the form of court ordered drug treatment or "diversion-to-treatment" programs. The survey of public attitudes in Alberta undertaken in Chapter 3 indicated that only 31% of Albertans believe that "pregnant women should be able to decide for themselves whether or not they drink alcohol". Similarly, only 22% of Albertans agreed that "pregnant women should have the final say over whether or not they receive treatment" and 61% agreed that "pregnant women with an alcohol problem should be required by law to enter a treatment program". This data indicates that Albertans in general feel strongly that a growing fetus needs to be protected inside its mother's body, and are supportive of means necessary to achieve that. Given these indications of public support for coercion of pregnant alcohol using women, the focus of this chapter will be to assess ethical justification for the most coercive of formal social control interventions, that of mandated treatment.

Previous analyses surrounding the morality of forcing treatment on alcohol abusing pregnant women have often focused on pitting the rights of women against those of the fetus.[5] However, the field of public health moves away from the idea of an individual person as patient and instead seeks knowledge and strategies to increase the health of populations as a whole. Public health is thus uniquely situated to bring to light, and put focus on, the interests of the *public* in the matter of prenatal exposure to alcohol and the appropriate role for society to take in addressing this public health issue.

This chapter will begin by framing the issue of maternal alcohol use as a public health ethics issue. I will then move into an exploration of some of the key values at stake, and perspectives at hand, by briefly considering a few common ethical arguments in the arena of maternal-fetal rights conflict. I will then systematically apply two recently published frameworks for public health ethics (Childress et al., 2002 and Upshur et al., 2002) to determine how they assess the normative question of what social control mechanisms are justifiable to impose on pregnant women who are using alcohol, specifically whether or not a public health ethics approach can justify compulsory treatment for alcohol using pregnant women. Finally, I will seek creative insights from ethic of care and population health approaches.

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[5] See for example: Bell, Richard D. (1997) "Prenatal substance abuse and judicial intervention in pregnancy". University of Toronto Law Review, 55(2): 321-340. and Capen, Karen (1997). "Mother's rights can't be infringed to protect fetus" CMAJ, 157(11):1586-1587.

Framing Maternal Alcohol Use During Pregnancy as a Public Health Ethics Problem

It is certainly reasonable to assert that communities have a legitimate interest in the health status of children. The health behaviour of pregnant women will have a great impact on the type of "start" that babies get off to. Low birth weight and fetal alcohol syndrome/effects are examples of conditions that can have negative health impacts over a child's entire lifetime. Both of these are linked to maternal abuse of substances during pregnancy (e.g., tobacco, drugs, alcohol) (Alberta Health and Wellness, 1999).

Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) have been recognized as one of the leading causes of preventable birth defects and developmental delay in children (Health Canada, 1996). Health Canada's Canadian Perinatal Surveillance System (1998) reports the estimated national rate of FAS to be 1 to 2 per 1000 live births, indicating that more than 350 children are born with FAS each year. The incidence of FAE may be several times higher than this (Health Canada, 1996) and the incidence of both FAS and FAE appear to be much higher in some Aboriginal communities (Canadian Perinatal Surveillance System, 1998).

It has been estimated that the additional health care, education, and social services required by an individual suffering these effects costs about $1.4 million over their lifetime (Square, 1997). In Alberta, AADAC (Alberta Alcohol and Drug Abuse Commission) reports that an estimated 29% of children in government care have likely been affected by their mother's use of alcohol during pregnancy. Many of these children will have mental health problems, disrupted school experiences, trouble with the law and suffer alcohol/ drug problems of their own.[6]

Thus, it is clear that when examining health status indicators at a population and community level, prenatal substance abuse has an impact. Limited education, patterns of substance abuse, and poor mental health that may result from FAE/FAE are all broad determinants of an individual's mental, physical and social well-being.

What I propose is that the tragic picture painted here is representative of more than just a description of the health status of "the others". The phenomenon of FAS/FAE in our communities affects more than just those individuals who carry the affliction, and even more than those in their immediate circle of friends and family. The pathways and mechanisms by which prenatal substance abuse affects the health of a population are as subtle, complex, and interrelated as the ways in which things like low birth weight and FAE/FAS affect the health of an individual. If we take, for example, the estimated measure that 60% of individuals diagnosed with FAS/FAE will have trouble with the law (Streissguth et al, 1996) and we assume (I think reasonably) that their criminal behaviour is related to their FAS/FAE diagnosis, we begin to see the immense social benefit that would result if we could abolish the incidence of this preventable affliction. We can imagine how reduced crime rates would translate into safer, more cohesive, and healthier *communities.* Furthermore we can imagine the ways in which the estimated 1.4 million dollars that it currently costs the system to care for an individual with FAS/FAE, could be spent in a myriad of other ways to improve and invest in the health of the overall population. Sanda Rogers (1999) has pointed out that economic justifications are not a legitimate basis by which to curtail individual autonomy via state intervention (page 295). While I agree that economic reasons are not inherently persuasive in moral discussion, I do not think they can be ignored as at least one point of consideration in a health care system which is bound by fiscal realities. The reality is that resources spent in one place have the opportunity cost of resources that cannot be used in other areas. Whether it be for more accessible hip replacements, cardiac surgeries, or nutrition programs for expectant mothers, funds spent as a result of prenatal alcohol exposure could certainly be put to good use elsewhere in the system if this preventable problem could be ameliorated.

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[6] Estimates on this vary slightly according to source- refer to DSAT-Ontario (Fetal alcohol Syndrome and Effects Assistance and Training) at www.home.golden.net/~fasat/facts.htm

Taken as a whole, I find this vested interest perspective (i.e. that the community has an interest in ensuring health pregnancies and therefore some rights to intercede) to be quite compelling. Many previous arguments against judicial intervention in pregnancy have seemingly indicated that the matter is such a strictly private, personal one that to intervene in any way is intolerably invasive. In its final report, the Royal Commission on New Reproductive Technologies (1993) stated that *"a woman has a right to make her own choices, whether they are good or bad, because it is the woman whose body and health are affected, the woman who must live with her decision, and the woman who must bear the consequences of that decision for the rest of her life" (page 957).*

While I don't wish to refute this outright, I would like to suggest that the case of prenatal substance abuse may need to be examined with some different considerations than other cases of state intervention in pregnancy (such as the right to abortion or incidents of forced cesareans). The issue of substance abuse during pregnancy has more than one party at hand (i.e. the pregnant woman), and even more than two (i.e. the pregnant woman and the fetus). The effects of a woman's alcohol use during pregnancy infiltrate into the health of the broader population and the burdens are shared, though certainly not equally.[7]

Ultimately we *care* about the health of babies born into our communities. We care because of an interest on their behalf, a sense that they are deserving of the freedom of every opportunity for success in life. We also care about ourselves, with an objective to building, and living in, a healthy community where all members are able to contribute to its development and share in the benefits accumulated. For these reasons, the public has a legitimate interest in ensuring that pregnancies are as healthy as possible. However this point on its own is vastly insufficient to infer that forced treatment or other coercive means of intervention are the way in which we ought to ensure a healthy pregnancy happens.

Competing Interests: Maternal and Fetal Rights

Given that the issue of prenatal exposure to alcohol has traditionally received the majority of attention through dialogue around maternal and fetal rights, it is helpful up front to address some of the common arguments, controversial issues, and important distinctions that arise in this domain before moving on to an analysis through a public health ethics lens.

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[7] I wish to make it clear that by no means am I suggesting that the burdens born by members of the general public are greater than or equal to, those which are placed upon

When we try to compare any harms done to a woman with the harms done to a fetus she is carrying, we end up in very familiar territory for feminist ethics: the moral and legal status of the fetus. Because in addition to considering the *extent* of the harm, we need to determine if the fetus has any claim of a *right not to be harmed*. Furthermore, there is the question of whether a child (once born) has a right not to be harmed *before* birth, which may be different than the rights of a fetus.

At present, the fetus has no legal rights under Canadian law until born alive (Tremblay v. Daigle, 1989). Important legal precedent was set in 1997, regarding forced treatment for pregnant women in the case of Winnipeg Family and Child Services v. D.F.G., as described in Chapter 2. The results of this case were to establish that under current law, there is no recourse to mandate a pregnant woman to substance abuse treatment against her will. This case example serves to clarify the *present legalities*[8] around forced treatment, but does not answer all of our moral questions or state exhaustively how this issue ought to be handled in legislative policy.

Much literature has been written which attempts to discern the moral status of the fetus. While there is certainly no consensus on what the answer *is* or *ought* to be, there does seem to be some indication that there *is and ought to be* a moral distinction between a fetus and a *person-to-be*.[9] This distinction holds that the question of *whether* a child is

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the woman who struggles with substance abuse, the child suffering from the effects of damage in utero or the friends and family members of either.

[8] Note that asking or answering legal questions is a significantly different enterprise than asking or answering ethical ones.

[9] See for example : Purdy, 1996; Callahan and Knight, 1992; Warren, 1989; and Mackenzie, 1992.

born at all is a different question, morally and practically, than the question of *how* a living child will be affected by events that occurred before he/she was born.

The reason this distinction is critical to these discussions, is to establish that arguments over a woman's right to terminate a pregnancy *are not the same* as recognizing that a child, once born, and his/her community, has an interest in events that happened *before* he/she is born. Catriona MacKenzie (1992) describes the fetus, even at its earliest stages, as having moral significance "by virtue of its relations with one or more of the moral community" (page 143). Furthermore, she states that this moral significance, while not providing a right to life, does provide some grounds for fetus' claims to nurture and care.

However, demarcating the line between a fetus, which has no rights to life (at least no *current legal* rights), and a "person to be", which may have some rights to a healthy growing environment, is no easy task and is further complicated when we try to determine a point in time where this shift occurs.[10] Feminist literature has proposed interesting new models of pregnancy that can help us to understand the phenomenon as a lived experience (Mackenzie, 1992, Shanner, 1998). This conceptual work outlines how looking at pregnancy as an embodied experience illustrates the ways in which both the physical changes, and the changes in the moral position of the fetus, occur over such a gradual and ongoing process as to make its development fundamentally incompatible with a notion of a sudden accumulation of moral or legal rights. This concept offers much insight into the nuances of the questions surrounding the moral and legal status of the fetus, but certainly does not make it any *easier* to then delineate how we might answer the question of when fetal rights accrue (if it is determined that the fetus has some rights).

It is this consuming, problematic negotiation of the moral rights and standing of the fetus that has mired down arguments pitting women's interests versus fetal interests in many previous debates (e.g., issues of forced cesarean, abortion, forced treatment). Ultimately, I propose that this negotiation is not helpful, and perhaps not critical, to the public health argument at hand. For the purposes of the rest of this discussion, I will assume that whether or not the fetus had some claim to a safe environment while the harm was being done, once the child is born any harm done prenatally is certainly "counted", and added to the social and public harms that will be described in this chapter.

Applying Public Health Ethics Frameworks

Literature in the field of public health ethics has delineated ways in which public health issues are unique from traditional health ethics, or matters of clinical ethics, and highlights the particular value tensions that most frequently arise in this domain. Public health focuses its attention on the health of the population as a whole versus the health of particular individuals. In addition, as compared to medicine, the field of public health is less concerned with particular patient-practitioner relationships and interactions, and more concerned with the macro-level components of a societal health system such as laws, policies, and government and non-government health-related activities and programs (Childress et al 2002). In this section I will undertake a systematic analysis of

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[10] For example, legal rights accrue at the moment the child is born, alive, from its mother- but when might a fetus gain the right to a healthy growing environment?

the issue of social control of pregnant alcohol using women, by applying two promising new justificatory frameworks from the public health ethics literature.

Childress at al. (2002) and Upshur (2002) have both recently published frameworks designed to assist this process of sorting through specifically public health ethics issues against a fabric of ethical principles. I will apply both of these frameworks to the issue at hand by examining, through their respective lenses, a hypothetical policy that would require that *"any pregnant woman known to be drinking alcohol in excess, who is unwilling to voluntarily seek substance abuse treatment, will then be mandated to treatment"*. This hypothetical policy represents a high level of coerciveness when we consider the relative levels of coerciveness in the various social control interventions I have mentioned in this thesis. Again, I use it as a test scenario with the idea that if we can justify this most coercive intervention, we can consider less coercive interventions justifiable by default.[11]

Childress et al.'s Framework

Childress et al. (2002) have identified several "general moral considerations" that are predominant in issues of public health ethics. Specifically, the authors describe five justificatory conditions that can be used to help determine whether taking measures to promote public health in a particular situation warrants overriding other values such as individual liberty or justice (Childress et al., 2002, pg. 173). The five justificatory conditions named are: public justification, effectiveness, necessity, least infringement, and proportionality. In the following sections I will take each of these conditions in turn and apply them to the hypothetical policy stated above. Although Childress et al.'s framework suggests that failure to meet any *one* of these 5 conditions would suggest the policy cannot be ethically justified, I will consider *each* condition here for the purposes of a robust analysis, to be able to comprehensively *locate* all of the reasons why the policy is or is not justifiable, and to be able to systematically compare the analysis to that of a second justificatory framework and the empirical results of Chapter 3.

Public justification. This condition requires that policy makers explain and justify to relevant parties (including those affected by the policy), practices or policies that infringe on general moral considerations such as autonomy. Childress et al. (2002) suggest that public health agents ought to offer citizens "moral reasons, which in principle they could find acceptable". Since this condition is procedurally based, it is difficult to make any conclusions in a hypothetical case example. However, I can remark that this condition would require that policy makers show how and why they would consider the policy to be effective, necessary, proportional, and of the least restrictive means before any such policy was publicly implemented. Policy makers would have to clearly outline, in a robust manner, *how* they concluded that the infringement on women's autonomy was justifiable in light of the risks to child health associated with substance abuse during pregnancy.

Note that Childress et al.'s condition of public justification does not make the requirement that the public is in *agreement* with the proposed policy, simply that concerted effort be made to engage in a rigorous public justification process. The fact that

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[11] Note, however, that if this policy is *not* found to be justifiable, it does not hold

the empirical study showed widespread public support for coercive interventions, gives us information as to the currently held beliefs that might be taken into account in considering where the justificatory process might begin. Further public discussion, engagement, and debate would be necessary to facilitate a process of public justification, but for the purposes of coming to a conclusion for the analysis at hand, we can say that it is certainly plausible that policy makers could go through the necessary steps of appropriate public justification for the implementation of a mandated treatment policy.

Effectiveness. According to Childress et al., a basic criterion for infringing on someone's personal autonomy in the name of public health, is that the intervention will be *effective*. There are several components to consider here when examining this criterion. First of all, we need to be clear with regards to the goal about which we are trying to determine likely effectiveness. There are increasing amounts of empirical literature available in the addictions field that attempts to discern the relative effectiveness of compulsory treatment versus voluntary treatment for substance abuse. As pointed out by Wild et al. (2002), who took a comprehensive look at over 70 empirical studies in this area, the results are somewhat inconsistent and unclear (e.g., due to the heavy use of non-equivalent comparison groups in these studies). However, for the purposes of the argument at hand, the primary goal of getting a pregnant woman into treatment for her alcohol use is not a long term strategy to address her own alcohol problem, but rather a short term strategy to protect the fetus she carries. Thus, whether the treatment she receives is more or less effective if coerced versus voluntary becomes

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necessarily that a less coercive policy will also not be justifiable.

secondary in this argument to the fact that her coerced treatment will more than likely be effective at preventing alcohol from damaging the fetus she carries (the idea being that while residing in a treatment facility she will not have access to alcohol whether or not her desires to use change at all).[12] It would seem then, at first glance, that we can say this intervention of a mandatory treatment policy to force pregnant women into alcohol treatment, *will* be effective at abolishing or at least significantly reducing the incidence of FAS/FAE in our community. This conclusion only stands true however as long as we are looking at one particular case.

A significant concern that has been articulated in both the legal and ethical literature (see Winnipeg Child and Family Services v. G. (D.F.), SCC File No. 25508, paragraph 44, and Royal Commission on New Reproductive Technologies, 1993, page 958, respectively) is that policies of mandatory treatment would cause women who are abusing substances to avoid prenatal care out of fear of repercussions should their practitioner become aware of their behaviour. The question raised is whether a policy such as this would in fact exacerbate the problem at hand by damaging the trust relationship between pregnant women and their health care providers (Rogers, 1999, page 958). This potential avoidance of prenatal care, especially by those women who are part of a group likely in greatest need of this care, could result in a significant increase in harms to both fetal and maternal health (potentially negating some of the benefits as described in the above section). This concern I believe to be a very plausible and valid one, in consideration of the fear and uncertainty most likely felt by women dealing with an addiction at such a vulnerable time as pregnancy. Even those women who realize they have a problem and would like help with their substance abuse will likely feel much more reluctant to disclose their problem with the knowledge that the nature of the assistance they will get may not be on their own terms, within their current comfort levels.[13] If such interventions and policies were to become widespread, we need to consider the possibility that pregnant women would be increasingly likely to hide their alcohol use from health care professionals or other formal areas of support, or perhaps be too afraid to seek out prenatal care of any kind out of fear of being in trouble with the law, being committed to treatment facilities against their will, or having their babies, once born, or their other children seized by child protection agencies. If this were to result, the number of negative heath effects suffered by women and children has potential to actually increase. I think this concern is valid enough to make the issue of effectiveness in this framework at least questionable.

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[12] Note as well that since FAS/FAE are spectrum disorders, reducing a woman's alcohol use at *any* point during the pregnancy is of use since it may reduce the severity of the damage done to the resulting child.

Necessity. Childress et al. identify necessity as a condition required to justify public health interventions and state that "the fact that a policy will infringe a general moral consideration provides a strong moral reason to seek an alternative strategy that is less morally troubling" (pg. 173). This statement indeed resonates with regards to the issue at hand. A broad concern of mine is the failure of strategies such as compulsory treatment of pregnant, alcohol abusing women to recognize the true locus and nature of the problem. In terms coined by Virginia Warren (1992), forced treatment is a "crisis issue", whereas the real problem has been a lack of attention paid to "housekeeping issues" (page 37). Warren's terms describe a tendency in ethical deliberations to focus on sweeping, attention grabbing, high impact moral decisions at the expense of the daily, ongoing processes, problems, and needs that lead up to the crisis moment. Prenatal substance abuse should be taken out of the "crisis" limelight and addressed as an ongoing "housekeeping issue". Taking a step back for a moment we can see that the problem of women's substance abuse does not lie uniquely within the timeframe she is pregnant. If we are seeking strategies to reduce the incidence of FAS/FAE, we need to promote health among women overall, by recognizing that 1) women are not of value only during the time they are pregnant, 2) issues of substance abuse need to be addressed among women as a whole, holistically, and over their whole life span. We should ask ourselves-why does the issue of women's substance abuse only receive national attention and a scramble for effective interventions once a woman is pregnant?

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[13] For example, even a women who is interested in getting help in some format, may not wish to enter a formal treatment program, or may fear what will happen to her if she relapses from a voluntary program.

Chapter 2 included a description of the literature around women and alcohol abuse. I identified the ways in which women's substance use issues have been historically misunderstood, neglected from research and underserved in programming. It is here within these "housekeeping issues" where public health can play a significant and meaningful role in the primary prevention of harms associated with prenatal substance abuse. Where the attention is needed is not in the judicial system, once a woman is causing harm to her fetus, but rather in the systemic, structural, political and social realties that have led her to that spot.

Strategies in the public health arena have much to offer, including 1) seeking improvements in the contexts of women's lives that lead to addiction and a number of other negative health effects, 2) a determination of how best to attend to the needs of addicted women and address the barriers that are present, and 3) advocacy towards finding a place for substance abuse among women on research and programming agendas.

Given that there is much yet to be done in seeking alternative strategies, we cannot currently say then that than forced treatment is a *necessity* to prevent damage to fetuses from alcohol.

Least infringement. Childress et al.'s condition of least infringement requires that if a policy infringes on one or more "moral considerations", effort should be made to minimize this infringement as much as possible. Thus in the example of mandated treatment, the condition of least infringement would require that policy makers find the alternative that is the least restrictive of women's autonomy. However, the authors point out here that this condition is intimately related to the previous condition of necessity. In fact, Childress et al. go so far as to suggest that this condition could be considered as a "corollary" of the necessity condition, in that an intervention would need to be considered necessary in *degree* as well as *kind* (pg. 173). The idea is that once an intervention was deemed "necessary", the condition of least infringement then offers guidance as to how to enact the intervention. This point has an important effect on how we treat the condition of least infringement here in this analysis since I previously concluded that a mandated treatment policy would in fact *currently fail* the necessity condition, due to the lack of attention that has thus far been paid to the "housekeeping" issues associated with women's substance abuse. Given this, a policy of mandated treatment will also *currently fail* the condition of least infringement unless or until we do establish that *after having tried* alternative options (as described in the section on necessity), we find that mandated treatment *is in fact necessary*. It is worthwhile here though to imagine however, that if we were in fact to determine, in the future, that mandated treatment was *necessary*, how then would the condition of least infringement play out?

In order for an intervention such as forced treatment for a pregnant alcohol-using woman to meet this condition of least infringement it would have to be established that less restrictive attempts to control her alcohol use had been made, including concerted efforts to support her in voluntarily seeking treatment and comprehensive efforts to identify and remove the barriers to treatment she might be experiencing, and/or perceiving. It is worthwhile to highlight again here that in the landmark case of Winnipeg Child and Family Services vs. G.(D.F.), Ms G. had actually voluntarily sought out treatment for her glue sniffing addiction prior to being apprehended and forced into treatment. At the time she sought treatment, Ms G. was turned away due to lack of space in the system to treat her. When the social services agency worker later came to escort Ms G. to a treatment facility, she was intoxicated and refused to go. The social services worker proceeded to apply for a mandatory detention order, setting the wheels in motion for this case that ultimately found its way to the Supreme Court, but one wonders if perhaps Ms G. would have been successfully and voluntarily subscribed into the treatment facility if only the treatment had been available quickly.

If a given pregnant woman has refused treatment, mandating her to a treatment facility could meet this least restrictive criterion (once the necessity criterion had been established) provided the order is carried out in a manner which is as supportive and respectful as possible, and sensitive to the particular needs of the woman involved. This might include, for example, ensuring she is invited to all case consultations/meetings about her planned treatment; paying attention to and addressing particular needs she has regarding child care, loss of employment/income, family obligations etc.; providing her detailed information on where she is going, what to expect, how her treatment will proceed; and giving her options where possible on the particular program she will enter and the date she starts. As mentioned though, given the concerns highlighted in the discussion of the necessity criterion, and given that I currently don't believe a mandated treatment policy can meet this necessity criterion, it also therefore fails the least infringement criterion.

Proportionality. This justificatory condition requires that the benefits that are likely to result from a proposed policy that would mandate alcohol using pregnant women to treatment would outweigh the probable harms. Much of traditional public health ideology has been rooted in this utilitarian ethical framework. We seek interventions that will have the greatest good for the greatest number, and measure our progress by broad brush-strokes of population health status indicators. Starting with a weighing of the benefits of mandatory treatment I will begin with one of the most obvious that we would hope for- a reduction in the number of children born with FAS/FAE. It is impossible, within the confines of this work, to estimate the number of cases that a policy of forced treatment would actually capture. However it is reasonable to assume that with such a policy in place, many women who are currently known to physicians, social services agencies, concerned family members etc., to be consuming alcohol while pregnant, would be mandated to treatment facilities where alcohol would not be available. Their confinement in this way might then translate into a significant reduction in babies born suffering the effects of alcohol. However, as described above, the *overall* effectiveness of a mandating treatment policy is questionable due to the concern of damaging the trust relationship between women and their health professionals and potentially driving women in need away from pre-natal care.

Another potential benefit relates to the number of women who would receive alcohol treatment because they were mandated to do so; women who would otherwise not enter treatment programs of their own volition (for any number of reasons, e.g., because they did not believe they needed it, did not think it would work, had fears associated with entering the system in this way, etc.). It is unlikely that most pregnant, addicted women are intentionally and purposefully wishing to do harm to their fetuses. A mandatory treatment policy may serve to assist a pregnant woman in undergoing the necessary treatment so that she, *and* her baby, are free from the harmful effects of her substance abuse. Although the empirical evidence that mandated treatment is more or less effective than voluntary treatment is far from clear (Wild et al, 2002), we can assume that at an individual level there will be at least *some* women who will benefit from mandated treatment who otherwise would not have received this help.

Finally we can include a broad category of benefits that include those associated with the betterment of society and communities as a whole. This category relates to the societal effects of FAS/FAE as described earlier in this chapter and would include, for example, 1) reduced crime rates (and therefore safer communities)[14], 2) a lessening of the economic burdens associated with supporting these affected children (translating into a reallocation of scarce financial resources to other health/community needs), and 3) the benefits associated with the more abundant societal contributions that would be possible from healthy, flourishing community members who otherwise might have been less able to contribute their talents if suffering the complex affliction of FAS/FAE.

Moving now to a consideration of the potential harms likely to follow from a policy of mandated treatment for pregnant women using alcohol, many complex questions are raised. My first concern here has to do with the infringement on the confined woman's autonomy and affront to her right to make personal health care decisions. Our current medical ethic is strongly rooted in the principle of respect for autonomy that has been beneficial in protecting the vulnerable and has allowed people the liberty to live and die with dignity and by their own values. We can imagine the myriad of ways in which this undermining of her autonomy might negatively affect such important considerations as her mental health, confidence, resolve in addressing her addictive behaviour, belief in her ability to be a good mother, and the effectiveness of a treatment program.[15]

It is relevant here to engage the question of why respect for individual autonomy is so weighty, especially as it relates to the issue at hand. Within the literature review of

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[14] This claim assumes a causal relationship to the high correlation of criminal behaviour and FAS/FAE. This assumption is supported by FAS/FAE research on cognitive function and behavioural disorder/deficits, (ie. see Health Canada, 1996,a), but further analysis of this causal relationship is outside the scope of this thesis.

Chapter 2 I outlined in detail the nature of autonomy and the ways in which it is described in various fields. Major points to recall from this previous examination of autonomy include 1) the conditions of autonomous action as laid out by Beauchamp and Childress (1994): intention, understanding, and a lack of controlling influences, 2) the role that context and relationships play in one's ability to develop into an autonomous agent and to make autonomous decisions, and 3) that the development of the self towards an autonomous state is a move which is integral to psychological growth and well-being (Ryan 1995).

The question inevitably arises in this discussion as to whether or not a woman under the influence of drugs or alcohol is even an autonomous agent, or making autonomous decisions. Beauchamp and Childress suggested that this question would fall into consideration on the potential criterion of authenticity, or perhaps under the criterion of *non-control*. The argument might be that if the alcohol-using woman in question was not autonomous (due to influence by drugs/alcohol), we would therefore not be *imposing on her autonomy* when we mandate her to treatment. To date neither the ethical or legal literature has reached any resolution that an addicted individual is not an autonomous agent. A major problem in doing so is that autonomy is not static. The fluid nature of autonomy and autonomous action make it difficult, if not impossible, to make policy based on some broad assumption that *people using drugs/alcohol are not autonomous agents*. Further to this, my interpretation of the literature on autonomy, especially the points deriving from the psychological and feminist camps, is that our responsibility as

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[15] We could also consider here, the harms that may result for a woman's husband,

society/policy makers would not be to take advantage of individuals we might identify as lacking autonomy in some way, but rather demands that we find ways of respecting, nurturing and supporting a growth towards autonomous action for these individuals.[16]

Autonomy, however, is certainly not an all-encompassing, overarching right. There are necessary limits to what we can and cannot do based on the goals of living in a cooperative, safe and healthy society. Many public health measures are rooted in overall health benefits and are driven much more by concepts of consequence than duty. There is fluoride in our drinking water, although individually we never consented to receiving it, there are traffic rules we must follow or risk punishment, and there are limits to where we can smoke due to the harm it can pose to others. Although these interventions are not entirely uncontroversial, from the perspective of the field of public health they have been ethically justified. The question is then whether or not public health interests can also justify a policy that said pregnant women cannot use substances and then use forced treatment to enforce this policy.

In order to illustrate some morally relevant differences here, I will examine two examples of forced treatment. Under Alberta's Public Health Act, a person who is known or suspected to be infected with a communicable disease can be held in a treatment facility, subjected to examination and given treatment against their will, through the authority of quarantine and isolation orders. This Act allows an undermining of a

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children or other member's of her social network if she were to be forced into treatment.

[16] Note that proponents of compulsory treatment might argue that such a policy would in fact foster autonomy- i.e. by restricting choice temporarily, they are fostering the individuals future capacity for exercising their autonomy (without the influence of their addiction).

person's authority and right to refuse treatment, not because it is in their own best interests, but because it is necessary to protect the public. We saw quarantine measures put to use rather recently in the SARS outbreak in Toronto, with relatively little public outcry regarding the infringement on personal autonomy of individuals suspected of being exposed. This is an example of a policy/law that *is* in place, but also I think an example of a policy that *ought* to be in place and one that could be rather easily ethically justified. So how does this example compare with the case of a woman who is detained and stripped of her right to refuse treatment in the interests of protecting both the fetus at risk and the community who will bear the effects of her substance use?

The relevant difference, and what I feel is the most important concern in this examination of proportionality, is rooted in the idea of discrimination. A policy written about individuals who contract a communicable disease is not written about any particular *type of person*, in that anyone could potentially catch a communicable disease. On the other hand, a policy directed at individuals using substances while pregnant, will by definition only be applicable to women. Such a policy would therefore be discriminatory and not in keeping with Canadian values and priorities as laid out (in the legal realm) in our Charter rights. For example, in Brooks v. Canada Safeway Ltd. (1989), the Supreme Court of Canada ruled that discrimination based on pregnancy constitutes sex discrimination (Royal Commission on New Reproductive Technologies, 1993, page 967). Although it is certainly important to keep a distinction between ethics and the law, I believe that Canadian policy and law around discrimination is an example where ethics and the law are indeed in line with each other. Thus we see that while breaches of rights to autonomy may sometimes be warranted for public health reasons, there are clear reasons why policy around alcohol use during pregnancy ought to be handled differently.

When we take consideration of the broad concerns related to discriminatory policies and practices, the consequence-based argument for imposing a policy of mandated treatment begins to break down in light of the weight of the numerous social and public harms that could result. Sue Sherwin has pointed out that in contrast to traditional measures of utility, we perhaps ought to be counting the preferences of oppressed groups *differently* (Sherwin, 1992, page 21). When we are weighing these benefits and burdens, it matters *who* the burdens are put upon. Emerging literature in the area of feminist ethics (especially Sherwin, 1998) has suggested that we need to pay *particular attention* to the autonomy of historically oppressed groups (such as women), for example by examining how society contributes or detracts from their ability to develop into autonomous agents and how policy affects the ranges of choices available for them to take autonomous action.

Feminist ethical literature has illuminated the history of ideas and medical culture that has served to undermine the rights of women, medicalize their experiences, and reduce their roles to those contributing to reproduction (see for example Mitchinson 1998). Furthermore, gender is a recognized determinant of health, and many women's health issues function in accordance with the status and role of women in society (Health Canada, 1996). Therefore we can reasonably assume that law or policy that propagates disregard for the rights of women and reduces their value to that of "fetal environments", will have negative effects that ripple through the multitude of pathways by which health is determined.[17]

Given this potential for social harms, and especially in light of the harms associated with imposing discriminatory policies on women, I conclude that this policy would not meet the proportionality criterion of Childress et al.'s justificatory framework.

Upshur's Framework

In a second framework for public health ethics, Upshur (2002) identifies four principles used to determine whether a public health intervention is justified. I will now apply these four principles, the principle of least restrictive means, the transparency principle, the harm principle, and the reciprocity principle, to this same issue of mandating treatment for pregnant substance abusing women to determine if the outcome changes.

Least Restrictive Means. The first of these principles, the principle of least restrictive means, is the same as Childress et al.'s condition of least infringement, and thus need not be explored again in detail. I will however point out that under the Childress et al. framework, the condition of least infringement failed primarily due to its relationship with the condition of "necessity", and the fact that the necessity condition failed under current societal conditions and priorities. The context in the Upshur framework is slightly different since there is no corresponding "necessity condition", however the "least restrictive means" condition still falls to the same weakness. Upshur says here that "more coercive methods should be employed only when less coercive methods have failed" (page 102), therefore in essence subsuming Childress's et al.'s "necessity condition" within his own "least restrictive means" condition. The result of course is that again we cannot currently conclude that mandated treatment is the least restrictive means without having comprehensively tried less restrictive alternatives (such as those I outlined in the discussion on necessity).

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[17] For example, the Council on Ethical and Judicial Affairs, American Medical Association (1991) provides an excellent overview of the health disadvantages women

Transparency principle. The second principle, the transparency principle, overlaps significantly with Childress' principle of public justification, and thus again I will not repeat an analysis of this principle. I will mention however that Upshur places additional emphasis on the importance of transparency as it relates to the *procedural* aspect of decision-making/policy making as well the justification of the outcome/decision. He highlights the importance of involving all legitimate stakeholders in the process of decision-making. I concluded previously that the hypothetical policy at hand has the potential to meet this sort of condition.

Harm Principle. The next principle in Uphsur's framework is the "harm principle", based on John Stuart Mill's contention that: *"The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant"* (pg.102; quoting Mill). The question at hand is whether or not someone *other* than the pregnant woman is being harmed by her alcohol use. Without getting mired down in the unclear business of fetal rights, we can say for certain that the

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face due to their under-representation in research and clinical trials and various disparities harm principle is met by the virtue of the harm suffered by the *children who are born* with FAS/FAE caused by pre-natal exposure to alcohol.

Reciprocity principle. The reciprocity principle, as described by Upshur (pg 102), describes the duty of public health agents to properly support the individual in the discharge of their ethical duties and requires that the individual suffering the encroachment of the policy be appropriately compensated. It is my view that this principle is feasible to be met in a policy such as the hypothetical mandated treatment one we are exploring. This requires us to assume that with regards to support, once an order of treatment was mandated, the treatment a woman would receive would be inclusive of her needs for comfortable living arrangements, pre-natal care, nutritious food etc.[18] In addition I would expect this type of "public support" to also include more imaginative supports such as compensation for loss of income/employment or assistance with arrangements for any necessary child care (or other dependents). With regards to compensation, the benefits she would reap are far from insignificant in that she would receive treatment for an addiction that is more than likely interfering with her ability to flourish in life and also a far better probability of a healthy child. I would consider these benefits to be appropriate compensation for the temporary loss of liberty and privacy.

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in clinical decision-making.

[18] This is not to assume that any particular woman would not have these conditions in place prior to being mandated to treatment- merely to state that her treatment would include these types of supports so an not to impose additional burdens on her to arrange as she "discharges her ethical duty".

Results of Applying Frameworks to Mandated Treatment Example

Table 10 summarizes the results of applying these two justificatory frameworks to the issue of mandated treatment for pregnant substance abusing women. This hypothetical policy we have explored does not comprehensively meet all of the justificatory conditions necessary to satisfy either the Childress et al. framework or the Upshur framework. With respect to the Childress framework, the policy falls short in the effectiveness, necessity and proportionality conditions. And with respect to both the Childress and Upshur framework the policy will potentially fall short on the criterion of being the least restrictive means to meet the objective (unless or until we can first establish the policy is *necessary*).

Table 10: Justificatory Frameworks Applied to Issue of Mandated Treatment for Pregnant Women

Childress et al Framework		**Upshur Framework**	
Justificatory Condition	**Condition satisfied?**	**Principle**	**Condition satisfied?**
Effectiveness	Questionable (especially at a broad policy level)		
Necessity	No		
Proportionality	No		
Public justification	Feasible	Transparency	Feasible
Least infringement	No (unless/until we first determine policy is necessary)	Least restrictive or coercive means	No (unless/until we first determine policy is necessary)
		Harm	Yes
		Reciprocity	Feasible

Overall it appears that in order to ethically justify a mandatory treatment policy with these frameworks we would need to, at the least, have first sunk considerable effort and resources into 1) broadly improving the lives of women in such a way as to ameliorate problematic alcohol use by women as a whole, and 2) on a individual basis, seek every less coercive means possible to provide treatment for a pregnant alcohol using woman prior to mandating her to treatment. However, while these sorts of tactics might help us justify specifically with the conditions of necessity, and least infringement/least restrictive means, we still run up against the barrier of creating a *discriminatory policy,* which, at least within the Childress et al framework, will cause the justification of mandated treatment to fail within the condition of proportionality.

Some Insights from Population Health and Ethic of Care Approaches

The systematic ethical analysis undertaken here has concluded that imposing mandatory substance abuse treatment on pregnant women is not an ethically justifiable practice, in spite of the health benefits for the vulnerable developing fetus, due to the potential grave effects of infringing on women's autonomy in this way. This conclusion rests importantly on the idea that there might be less restrictive means of approaching this public health problem that are actually more effective in improving the lives of women and meeting the goal of healthy babies.

The Royal Commission on New Reproductive Technologies (1993) used an ethic of care approach in their deliberations, which promoted "creative solutions that can remove or reduce conflict" and "helping human relationships to flourish by seeking to foster the dignity of the individual and the welfare of the community" (chapter 3, page

52). This "ethic of care" approach[19], frequently discussed in feminist ethics literature, is rooted in Carol Gilligan's groundbreaking work in moral development in which she distinguished a "voice of care" from a "voice of justice" (see for example Gilligan, 1987). Gilligan highlights these two voices as different, but not mutually exclusive, moral orientations and argues that the *voice of care* should not be considered subordinate in any way to the more traditional *voice of justice*. Gilligan posits that the *voice of justice* holds that the moral viewpoint must be impartial, is derived from a set of principles that are universal and abstract, and emphasizes individual rights. Alternatively, the care orientation rejects impartiality and instead embraces the nuances of the particular contexts people are embedded in, and the web of relationships that surround them. Alisa Carse (1991) expands on this by noting that the ethic of care approach has both methodological and normative implications. Carse (pg 17) notes that with regards to process, *"care reasoning is concrete and contextual rather than abstract; it is sometimes principle guided rather than always principle derived, and involves sympathy and compassion rather than dispassion."* Speaking in a normative sense, Carse then remarks that the *"ethic of care asserts the importance of a concern for the good of others and of community with them, of a capacity for imaginative projection into the position of others, and of situation-attuned responses to other's needs."*

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[19] It is imperative to mention that my description of an "ethic of care" approach here is very limited, and meant merely to highlight some perspectives that this approach might offer to the problem of alcohol use during pregnancy. A complete review of this broad and important body of literature is outside the scope of this thesis. For some examples, see Gilligan, Carol (1982). In a Different Voice. Cambridge, MA: Harvard University Press, or Kittay, E. & Meyers, D. (1989). Women and Moral Theory. Stony Brook, NY: Rowman and Littlefield.

I find this approach to be very much in keeping with emerging population health frameworks within public health that promote awareness and understanding of the variety and relatedness of social determinants that impact health and the mechanisms by which they act.[20] Keeping these perspectives in mind it becomes clear that pitting the interests of the public against those of the mother will likely get us no farther than pitting those of the fetus against those of the mother. In such scenarios, it doesn't matter if the conclusions we reach are morally sound, somebody's interests are being compromised by the very nature in which the conflict was set up. A better goal would be to seek ways in which public health advocates could work on behalf of, and alongside women, to ensure decisions made during pregnancy are healthy ones for all parties involved. This would include such things as varied interventions to address the economic, educational and safety needs of women in effort to prevent women from being susceptible to alcohol abuse behaviour, as well as strategic and inventive alcohol treatment programming that is both accessible and designed to meet the specific needs of women. As outlined in Chapter 2, there are particular contexts in women's lives that, to date, addiction research has not adequately examined from a gender perspective, as well as unique treatment barriers that women- including pregnant women- face. Population health and ethic of care approaches promise innovative ways to make strategic progress in this women's health issue without resorting to forced treatment.

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[20] see for example: Federal, Provincial and Territorial Advisory Committee on Population Health. Strategies for Population Health: Investing in the health of Canadians. Ottawa: Health Canada Publications, 1994.

One problem, which arises repeatedly within the context of addressing the social determinants of health, is that of urgency. Improving the social and economic circumstances of women as a general population by means of appropriate research, policy, funding priorities etc. is by no means an overnight solution. Rather, we can expect that resulting changes in the lives and status of women will occur slowly and incrementally, likely over more than one generation. This is however far from an argument to abandon these measures, and more of a cry for immediate action and attention to the problem.

Summary

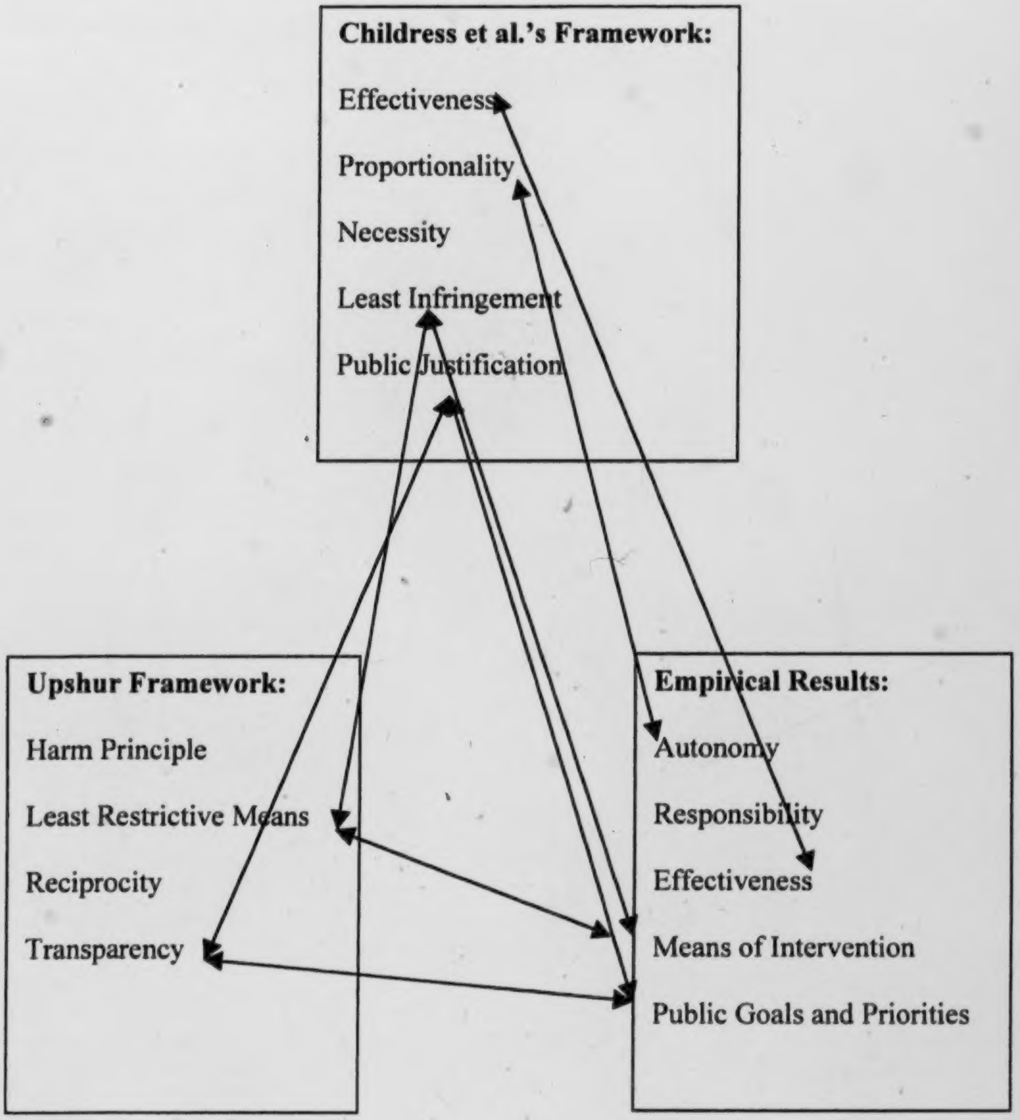
This chapter has undertaken an ethical analysis of the question of justification for imposing social control mechanisms on pregnant women using alcohol. I first articulated why the issue is of such paramount importance to society and framed the issue as one appropriate for analysis as a public health ethics problem. I then briefly described the problem I see with examining the issue from the perspective of maternal versus fetal rights and then turned to two justificatory frameworks recently published in the public health ethics literature to further tease apart the issue and determine where the major points of concern were. I found no ethical justification for a broad policy of mandated treatment for alcohol using pregnant women. Finally, I highlighted the similarities between a population health and an ethic of care perspective and suggested that these orientations would have much to offer as a means of addressing the "housekeeping" issues related to women's alcohol use (such as making appropriate treatment available for women and taking strategic steps to encourage women to get help), throughout their whole life span and not merely as a "crisis" issue during the time a woman is pregnant.

Chapter 5: An Integration of the Empirical Study Results and Ethical Analysis

Introduction

In Chapter 3 I described the results of an empirical study that looked at public attitudes surrounding social control mechanisms imposed on pregnant, alcohol using women as compared to alcohol users in general. In contrast, Chapter 4 used conceptual, rather than empirical, tools and examined the justification for such interventions imposed on pregnant women. The objective of Chapter 5 will be to bring together the findings of these two different methodological approaches and to determine what these two chapters have to say to each other. Figure 5 provides a map of the terrain covered thus far and illustrates the relationships between concepts employed by the various frameworks. This figure depicts the conditions for the two justificatory public health ethics frameworks applied in Chapter 5 (Childess et al.'s and Upshur's), as well as the five categories of survey questions investigated in Chapter 3. Arrows indicate a relationship of similarity among the subheadings of these three frameworks. "Public justification", "transparency" and "public goals and priorities" are shown to have a relationship across all three frameworks. Similarly, "least infringement", least restrictive means", and "means of intervention" have a relationship spanning all three frameworks. "Effectiveness" is a subheading in both the Childress framework and the empirical study of Chapter 3. Finally, although most of these conditions are in some way related to the concept of autonomy, I have highlighted the relationship between autonomy and proportionality as being the most useful to discuss. This chapter will compare and contrast the results of the various modes of inquiry used in this thesis and attempt to seek ways of integrating them.

Figure 5: Conceptual Map of Relationships Between Frameworks


Childress et al.'s Framework:
Effectiveness
Proportionality
Necessity
Least Infringement
Public Justification
Upshur Framework:
Harm Principle
Least Restrictive Means
Reciprocity
Transparency
Empirical Results:
Autonomy
Responsibility
Effectiveness
Means of Intervention
Public Goals and Priorities

Comparing and Contrasting Results

The results of the empirical study of Chapter 3 indicated that there would be general public support for both formal and informal social control mechanisms imposed on pregnant alcohol using women. The majority of respondents disagreed that women should be able to decide for themselves whether or not they consume alcohol while pregnant, and also disagreed that pregnant women should have the final say over whether or not they receive treatment for an alcohol problem. Furthermore, the majority of respondents indicated that they would support legal intervention that would require pregnant women with an alcohol problem to enter treatment programs.

The ethical analysis undertaken in Chapter 4 looked at the normative question of whether society ought to implement policies such as mandatory treatment for pregnant alcohol users, by 1) exploring the maternal vs. fetal rights perspective, 2) applying two justificatory ethics frameworks for public health interventions, and 3) describing the advantages of ethic of care and population health approaches to address this public health concern. Findings did not support ethical justification for the use of coercive tactics such as mandated treatment for pregnant women drinking alcohol.

Therefore I have found that public attitudes as measured in Chapter 3 are not entirely in line with the conclusions that I reached in the ethical analysis of Chapter 4. In the next section I will attempt to locate more specifically the source of dissonance between these results. In order to focus this examination, I will again specifically look at the issue that has arisen as the most contentious throughout this thesis- that of mandated treatment for pregnant alcohol using women.

Table 11 is a summary table of the application of the public health ethics frameworks to the issue of mandated treatment for pregnant alcohol using women (as undertaken in Chapter 4 ethical analysis), with the addition of a column commenting on the empirical results corresponding to the justificatory conditions.

My ethical analysis found that mandatory treatment was questionable with regards to *effectiveness* at addressing the problem of women using alcohol during pregnancy. This conclusion with regards to effectiveness was supported by the results of the empirical study, since the majority of respondents did not agree that forced treatment was "the *best* way to help a pregnant woman with an alcohol problem". Public attitudes also supported the idea, outlined in both the Childress and Upshur frameworks, that the least restrictive means necessary to achieve the objective should be employed when considering a public health intervention to control the behaviour of pregnant women. Public agreement for using the least restrictive means was illustrated by the increasing amount of support that was found for the various interventions as the level of coerciveness of the intervention decreased. Finally, the widespread public support for employing interventions to protect a fetus from being damaged by alcohol *in utero*, illustrated by the empirical study, suggested that the public, at least in general, might be receptive to a policy making and implementation process of the type necessary to meet conditions of public justification and transparency.

A significant point of departure, however, is with regards to autonomy and proportionality. The empirical results show repeated examples of a public willingness to compromise women's rights and freedoms in order to protect the fetus she is carrying (e.g., 64% of respondents thought that a pregnant woman should not get the final say as to whether or not she receives treatment; 52% of respondents disagreed that pregnant women should be allowed to decide for themselves whether or not they consume alcohol). Results also showed that the public generally views a pregnant woman's autonomy differently than they do the average person (e.g., public was *less* likely to agree that pregnant women should be allowed to decide for themselves whether or not they enter treatment, as compared to alcohol users in general). In contrast, the ethical analysis undertaken in Chapter 4 concluded that when balancing the respective benefits and harms of implementing general policies that encroach on women's freedoms in this way, we find that as a discriminatory practice, the potential harms outweigh the benefits. Thus it is within this autonomy/proportionality domain where I propose that public attitudes are in most disaccord with the conclusions of the ethical analysis.

Table 11: Results of Empirical and Ethical Inquiry into Issue of Mandated Treatment

Childress et al Framework		**Upshur Framework**		**Empirical Study**
Justificatory Condition	**Condition satisfied?**	**Principle**	**Condition satisfied?**	**Comments on empirical results as compared to ethical analysis**
Effectiveness	questionable			**[In agreement**.] Respondents tended to disagree that forced treatment would be the *most effective* means and also felt that addressing environmental issues was very important.
Proportionality	no			**[Disagreed.]** Respondents generally supported infringements on women's autonomy in order to protect fetus. Ethical analysis did not find justification for this.
Necessity	no			n/a
Least infringement	No (unless/until we first determine policy is necessary)	Least restrictive or coercive means	No (unless/until we first determine policy is necessary)	**[In agreement**.] Respondents tended to be more supportive of interventions as level of coerciveness lessened.
Public justification	feasible	Transparency	feasible	Evidence of public support for interventions with the goal of protecting a developing fetus, but reasons unknown.
		Harm	yes	n/a
		Reciprocity	Feasible	n/a

Negotiating Appropriate Roles for Various Sources of Information

The question that obviously arises at this point relates to the relative value of each type of information source- i.e. what ought we do to when it appears that public opinion is in dissonance with what a rigorous ethical analysis might deem to be justified? What responsibility does policy have to be in sync with general public attitudes and how ought ethics analyses inform public policy?

Chapter 3 gave us insight into the question of what public attitudes are and what moral beliefs are generally held. This is an exercise in descriptive ethics, that is, how *do* people feel/think about/address the issue of maternal substance use. In contrast Chapter 4 is an exercise in normative ethics as it asks the question of how *ought* this public health dilemma be handled, given reasoned, systematic ethical analysis. We can think about descriptive ethics as being a "starting point" in striving toward an ethical society. We need to determine the *is* (descriptive), so that we can compare it to the *ought* (normative), and therefore bring to light the direction in which we hope to head. What we would then hope to do is to work in the area between this gap and attempt to bridge these results.

Increasingly there is a push towards involving the public in decision-making and policy setting in the health care arena. Community priorities, beliefs and attitudes are crucial pieces of information when attempting to construct policy that will be appropriate, responsive to identified needs, and in keeping with core Canadian values. In addition, given the political climate in which policy is made, there is a likely requirement for at least a certain degree of public support for any proposed policy in order for it to be both a) implemented and b) utilized effectively.

On the other hand, it would certainly not be appropriate that every policy decision be made simply by a "vote" to determine the most popular public opinion. It is generally recognized that there is valuable input to be gained from those holding specialized knowledge of a certain degree and kind, and ethics is no different. There is certain merit in conclusions that are reached by thoughtful, rigourous, and systematic ethical analysis versus merely by compiling thoughts and opinions from the general public whose thoughts on a particular matter may in fact be ill-informed or underdeveloped.

The next process that I would suggest is critical to undergo when integrating the results of these two methodologies is one of reflection. We should reflect on the conclusions that were independently reached, especially in light of a discovery of dissonance between them.

Starting with a reflection of the empirical data, the descriptive ethics inquiry, my first reflection would be that a blunt (e.g., Likert scale) collection of public attitudes is not a sensitive enough instrument to truly identify public *values*, which in some instances may be more important pieces of information. For example, results of the empirical study indicate general support for coercive interventions to control the behaviour of pregnant women drinking alcohol. However, we could extrapolate on this information and hypothesize that the values represented by this attitude are for example: *health and well-being of community*, *protection of the vulnerable*, and *prevention of harms*. If we were to assume that it is these types of values that are primarily underlying publicly held attitudes about social control of pregnant women,[21] (and I think is safe to do so) we might be more inclined to conclude that the empirical information collected and the ethical analysis are not quite so dissonant after all. If public goals are for healthy birth outcomes, it is reasonable to assume that support would also be offered for less coercive interventions and support strategies as outlined in my discussion of ethic of care and population health strategies, *if* these could be shown to be more *effective* and *ethically justifiable* interventions.

Further reflections would question the legitimacy of public opinion which is not well justified or informed. I would suggest that it is irresponsible to base public policy on attitudes that do not arise from a comprehensive understanding of the various issues at stake and that are not well justified. A well-justified attitude should be able to explain and defend its position with clear, transparent and logical reasoning. While it is likely unreasonable to expect that members of the general public undergo such a rigourous analysis as that undertaken in Chapter 4 of this thesis, it *is* reasonable to require that public opinions that are taken into account in a decision-making process have a degree of reason and thoughtfulness behind them.

What this snapshot of public attitudes provides is insight into the currently held thoughts on social control of pregnant women and information as to where a public dialogue might begin. However what the questions raised upon reflection above suggest, is that perhaps the descriptive ethics inquiry has not yet been answered satisfactorily.

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[21] Community values are by nature, difficult to measure and assess. A different methodological approach (likely qualitative) would need to be used to identify the values in this case in actuality.

There is strong indication for further inquiry into 1) what values underlie these public opinions, 2) *how* and *if* supporters of coercive interventions could justify their positions, 3) how educated respondents are about the complexity of the issue. These further investigations would likely use qualitative methodologies, perhaps focus groups, to allow the opportunity to really hear, and tease out, why people hold the attitudes they do and how they justify them. I would hypothesize that fewer people would be as supportive of coercive means of controlling pregnant women's behaviour given additional information regarding the harms associated with gender discrimination, and the criminalization of women's health behaviour choices during pregnancy, as well as the current gaps in appropriate services for substance using women and pregnant substance using women. An interesting step here would be to administer a similar survey as the one that was done, to a particular group who had participated in an information/education session that familiarized respondents with the various arguments for and against using coercive measures to control pregnant women. However if results from a study such as this still yielded similar support for coercive policies as the study described in Chapter 3 did, it might well be indicative that we have a legitimate difference of opinion (versus an ill-informed opinion on the one hand), between the general public and an ethical analysis with regards to using coercive interventions to control pregnant women's behaviour.

The reflective stage of this integration of methodologies also requires that we reflect on the normative analysis. This reflection is one that should be taken at the end of any ethical analysis, but we have further motivation to do so if and when we have reached a conclusion that is seemingly out of line with general public attitudes (given that we strive to live in a democratic society where good policy does not ignore public goals and opinion). In my ethical analysis I concluded that the need to protect a developing fetus from harm, or a child from harm inflicted before birth, did not justify the broad dangers posed by implementing discriminatory policies upon women and infringing upon their autonomy. However public attitudes seem to indicate that these types of policies and practices would be publicly supported in order to prevent harms such as FAS/FAE. As I have stated previously in this thesis I consider this public interest in the healthy development of children prior to birth to be a legitimate one, and also feel that the harms done by alcohol abuse during pregnancy to be of utmost seriousness and tragedy. And so in what ways ought we to re-visit the ethical analysis? First of all of course we would revisit each assumption, argument and conclusion reached in the analysis to look for discrepancies, things that might have been missed, assumptions that are unreasonable etc. We would also want to examine the justificatory approach that was used. For example in this thesis I primarily analyzed the issue at hand from a public health ethics perspective, using two frameworks recently published in the literature. However, ethics is not a black and white business with given formulas that we apply and then confidently produce the *right* answer. Conclusions that are reached are heavily influenced by the theoretical approach that is taken to the question, and what factors of the case are deemed to be important. Using Childress et al. and Upshur's frameworks I applied a total of seven types of justificatory conditions. If it were the case that we found a discrepancy between informed and reasoned public opinion on one hand, and a rigourous, systematic ethical analysis on the other, it would be prudent to re-examine the justificatory conditions used and see if something is missing. Information gathered from the public on how they view the issue and how their attitudes are reasoned, may bring to light additional conditions or considerations that should be included in the ethical analysis and that would potentially change the outcome of such an analysis. Alternatively, information gathered from the public might provide insight into how a proposed policy ought to be modified in some way. In any case, it is my opinion that if ultimately we simply do not find not find any reconciliation between rigourous ethical analysis and general public attitudes (and I think this would be very rare), good policy has a responsibility to align itself with the "ethical" camp as I do not see a way that policy makers could justify undertaking actions that they did not consider to be *right* or *good*, simply because of general public opinion.

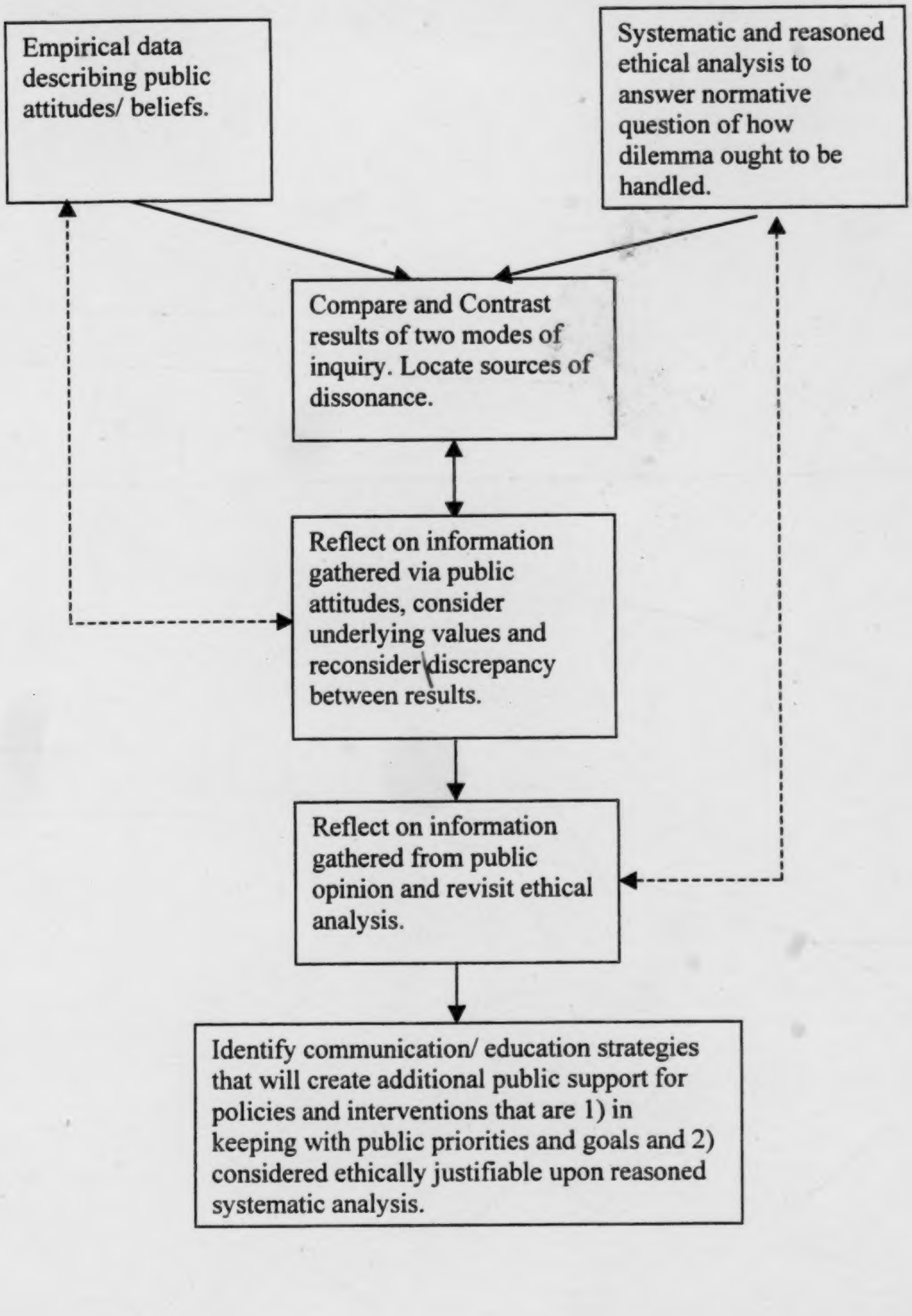
Previously I located the major source of disagreement between these particular descriptive and normative analyses to be within domain of autonomy, and whether the harms associated with infringements on women's autonomy are outweighed by the benefits. Knowledge gained by locating the source of the discrepancy allows us the opportunity to then effectively focus public education or knowledge transfer strategies. For example in discourse about appropriate public health interventions in this case, we now know that we need to explain the potential for rippling harms as a side effect of coercive policies geared towards pregnant women and the dangers that are inherent to discriminatory policies and practices. We also have shown that the public has an intuitive sense that less restrictive means of achieving the same objective are preferable and thus would likely be supportive of efforts to maximize the use of these types of alternatives.

A Framework for Integrating Empirical and Ethical Methodologies

This thesis has utilized both empirical and philosophical-based methodologies in order to examine the specific public health ethics question of imposing social control mechanisms on pregnant alcohol-using women. In order to do so, I used information that was gathered regarding public attitudes and compared this with a systematic ethical analysis in order to determine reasonable alternatives for public health interventions. Figure 6 provides a conceptual framework for navigating this mixed methodological process, one that could also be applied to other public health ethics issues. The framework begins with information gathering and analysis steps from within the different methodologies and then moves into comparing and contrasting results. After locating sources of dissonance we are then better equipped to communicate important information to the public and also create policy in keeping with public goals and priorities.

Integral components of this framework are the various points of reflection that are identified. I suggest that it is critical to reflect on the *values* underpinning the attitudes identified, and even attempt to identify and measure these values if permitted by the study design. Another critical step is to reflect on the information gathered from public attitudes/beliefs/values and consider the implications these bring to bear on the ethical analysis undertaken. This reflective process might provide new information that would result in a reconsideration of the conclusion reached.

Figure 6: Framework for Integrating Empirical and Ethical Approaches


Empirical data describing public attitudes/ beliefs.
Systematic and reasoned ethical analysis to answer normative question of how dilemma ought to be handled.
Compare and Contrast results of two modes of inquiry. Locate sources of dissonance.
Reflect on information gathered via public attitudes, consider underlying values and reconsider discrepancy between results.
Reflect on information gathered from public opinion and revisit ethical analysis.
Identify communication/ education strategies that will create additional public support for policies and interventions that are 1) in keeping with public priorities and goals and 2) considered ethically justifiable upon reasoned systematic analysis.

Summary

This chapter began with an overview of the various modes of inquiry utilized in this thesis including an empirical study which investigated the descriptive ethics question of what public attitudes *are* held surrounding maternal alcohol use during pregnancy, and an ethical analysis of the normative question of how *ought* maternal alcohol use during pregnancy be addressed. I then engaged in a description of the three predominant investigatory frameworks used in this thesis (survey questions, Childress et al framework, and Upshur framework) and how they are related to each other. Once these relationships were established I could then compare the results that were compiled across these frameworks and locate points of agreement and disagreement. Lastly, I developed a conceptual framework to illustrate how one might approach an analysis that is comprised of both empirical and ethical components, with a focus on how to negotiate the various pieces of information that arise from these very different methodological approaches.

Chapter 6: Final Conclusions and Recommendations

In conclusion of this thesis, my remarks are based at two different levels: 1) the more topical issue of the public health problem of maternal alcohol use during pregnancy, and 2) the broader issue of mixing empirical and ethical methodologies as a means of problem solving and how to integrate the results of these approaches.

The results of this research showed that, in general, Albertans are supportive of imposing formal social control mechanisms, such as mandated treatment on pregnant women using alcohol. I also found that, in general, Albertans viewed a pregnant woman's right to make decisions and act freely, to be somewhat different than that of a person in general. It is this suggestion of discriminatory attitudes that I find to be the most concerning result of this research. More promising however, is the finding that Albertans do not necessarily consider mandated treatment to be the *most effective way* we can address a pregnant woman's alcohol use, and that there seems to be a general recognition of the role that a woman's environment plays in contributing to alcohol use. In addition the results of this thesis showed that Albertans had an intuitive sense that using the least restrictive/less coercive means wherever possible was a more palatable approach in trying to get a pregnant woman to stop drinking. Another positive bit of news we can take from the results of the empirical study is that the majority of Albertans seems to at least *be aware* that drinking alcohol during pregnancy is an issue to be concerned about and that society *cares about* finding ways to protect a developing fetus from harm.

The ethical analysis I undertook in Chapter 4 analyzed a hypothetical policy of mandating alcohol using pregnant women to treatment. My analysis found that such a policy would not be ethically justified. I located the dissonance between public attitudes and the ethical analysis to be within the domain of autonomy and proportionality. Public attitudes seemed to suggest that an infringement on a woman's autonomy was justifiable for the sake of protecting her developing fetus and thereby allowing the future child the opportunity to flourish. My ethical analysis however suggested that the harms associated with such a discriminatory policy would be so broad, with so much potential to ripple further into the lives and status of women as a whole, as to make the harms outweigh the benefit. This is a key message that I would suggest policy makers interested in preventing FAS/FAE should be communicating to the public. Albertans need an increased understanding of the ways in which gender acts as a determinant of health and the importance of prioritizing support of women's rights and status.

Childress et al.'s condition of necessity is another criterion that brought to light important considerations for how the problem of FAS/FAE ought to be addressed. Here I pointed out the ineffectiveness of focusing concern about women's substance use only during the time they are pregnant. The patterns of reasons why women, in general, use alcohol (e.g., sexual abuse, domestic violence, poverty) tend to be significantly different that the patterns for usage seen amongst men. In addition, there are unique barriers to treatment that women, in general, experience (e.g., childcare, availability of appropriate treatment) compared to men. Public health policy needs to recognize that women's substance abuse issues have some important differences that traditionally male-centred research has not adequately illuminated. If we did a better job of addressing women's substance abuse issues overall, the incidence of FAE/FAE would naturally fall. Strategic planning to reduce the incidence of FAS/EAS should include focusing attention on improving women's health (broadly defined), and in particular substance abuse among women. It is reasonable to assume that a continued, and perhaps renewed, enthusiasm for efforts to address women's poverty, sexual abuse of women, domestic violence, unemployment, etc., would translate into reduced alcohol use by women.

Alberta should take steps to ensure that appropriate treatment is available for women who seek it and that the particular barriers to treatment that women might face are ameliorated. These steps will include, of course, additional research on what kind of treatment program is most effective for women, increased operational funding for treatment programs to ensure availability to women in need, and the capacity to use sensitivity and imagination in determining how we can best *care for* women struggling with substance use. Of course, even while addressing substance use among women as a whole, a sense of urgency arises when we come across a case where a pregnant woman is abusing alcohol. Here I think the best we can do is use encouraging and persuasive techniques, patience and sensitivity in trying our best to guide a particular woman to treatment.

At a macro level, this thesis was an exercise in mixing methodologies. Specifically I undertook both an empirical and conceptual research approach and then attempted to negotiate the various findings from these two inquiries. I suggest that good public health policy should take into account both public attitudes/opinions as well as systematic ethical analysis. In either of these two enterprises it would always be necessary to reflect on findings and revisit the process in order to reconsider, for example, if attitudinal data was interpreted correctly or critical ideas were missed in the ethical analysis. This reflection should be especially rigourous in cases where public attitudes seem out of line with the conclusions reached by ethical analysis.

Dissonance between the empirical and ethical modes of inquiry may be reconciled in at least three ways. Firstly, reconciliation might be achieved through further investigation into public attitudes, for example by examining the values that underpin these attitudes and providing more information to the public on the issues at stake. Secondly, it would be prudent to revisit the ethical analysis based on important considerations brought to light by the empirical work (for example reconciliation might be achieved if the empirical work identified additional considerations that resulted in a change in outcome of the ethical analysis). Finally, reconciliation might be sought by rethinking the details of the proposed policy based on findings from the ethical analysis and/or public attitudes. In cases where it is determined that public attitudes are simply not in keeping with reasoned ethical analysis, good policy will stay in line with what is ethically justifiable and effort should then be made to clearly articulate the reasoning and background information to the public in order to foster enlightenment and understanding.

Finally, I hope that this thesis is an example of the benefits that can be gained by interdisciplinary work. There are of course many associated challenges; different disciplines tend to speak almost in different languages, they prioritize different sorts of information, and place value on different types of outcomes. These differences can make it hard to find shared goals with regards to a research agenda and strategy. The overarching objective however, that makes confronting these challenges a worthwhile endeavor, is the hope that research findings are made better by being inclusive of what various disciplines have to offer, and also more applicable to a realistic context where people, programs, agencies, clinicians etc. do not operate within limited academic domains.

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Appendix 1: Telephone Interview Guideline

INTRO1

Hello, my name is ______________ and I'm calling (long distance) from the Population Research Laboratory at the University of Alberta. Have I dialed XXX-XXXX? Your phone number was selected at random by computer as belonging to a household in Alberta.

We are currently conducting a study called Public Attitudes Toward Addictions on behalf of the Centre for Health Promotion Studies here at the University. Over the next month, we will be interviewing 3,500 people in the province about how they feel about addictions. A wide representation of viewpoints is important to this study.

We don't always interview the person who answers the telephone. To ensure that we speak with a good cross-section of people in the province, could you please tell me the number of men aged 18 and older who live in your household?

NUMMEN

_________ # of men aged 18 and older

And the number of women aged 18 and older?

NUMWOM

_________ # of women aged 18 and older

NEXTBDAY

For this study, I would like to speak with the person in your household who is 18 or older and who will have the next birthday. Would that person be available to speak with me?

1 Yes-proceed
2 No-schedule callback for person (or code appropriately)

INTERVIEWER NOTE: REPEAT INTRODUCTION IF ANOTHER PERSON COMES TO PHONE

INTRO2

I would like to interview you and I'm hoping that now is a good time for you. The results of the study will help researchers understand the role of addictive behaviours in the lives of Albertans.

The interview will take about 15 minutes, but could take up to 30 minutes, depending on the questions that apply to you. Is now a convenient time for you?

1 Yes-proceed
2 No-schedule callback (or code appropriately)

FOIP

Before I go on, I would like to assure you that your participation in this interview is completely voluntary. If there are any questions you don't wish to answer, please point these out to me and we'll go on to the next question. You, of course, have the right to end this phone call at any time. The information we are requesting in this interview is protected under the Alberta Freedom of Information and Protection of Privacy Act and will be used only for research purposes. Only the researchers will have access to the information you provide, and they will store the information in a locked cabinet for 5 years at the University. The information gathered for this study may be looked at again in the future to help us answer other study questions.

If so, the Ethics Board will first review the study to ensure the information will be used in an ethical manner.

Nobody will be identified individually in any reports coming out of the survey. If you have any questions about this study, you can call Tina Wu, Project Coordinator at the Population Research Lab at 780-492-4659, ext. 229. Do you have any questions right now?

ETHICS1

As part of the ethics requirement for this study, I need to confirm that you understand the information I have just read to you.

Do you understand that you have been asked to be in a telephone research study?

1 Yes

2 No (GO BACK TO INTRODUCTION AND READ INFORMATION)

3 Don't know (GO BACK TO INTRODUCTION OR TERMINATE)

0 No response (GO BACK TO INTRODUCTION OR TERMINATE)

ETHICS2

Do you understand that I need less than 20 minutes of your time today, that everything you tell me today will be kept completely confidential, and that no one other than the researchers on this study will have access to any of the information provided?

1 Yes

2 No (GO BACK TO INTRODUCTION AND READ INFORMATION)

3 Don't know (GO BACK TO INTRODUCTION OR TERMINATE)

0 No response (GO BACK TO INTRODUCTION OR TERMINATE)

ETHICS3

Were you provided with the name and telephone number of the project coordinator who you can call with any questions about the study or your participation in the study?

1 Yes

2 No

3 Don't know

0 No response

ETHICS4

Do you understand that your participation in this study is voluntary, that you have the right to end this interview at any time, and that if there are any questions you don't wish to answer, you can point these out to me and we'll go on to the next question?

1 Yes
2 No
3 Don't know
0 No response

ETHICS5

Finally, do you understand that nobody will be able to identify you personally in any reports coming out of the study?

1 Yes
2 No
3 Don't know
0 No response

TIMENOW

Appendix 2: Alcohol Module Survey Questions

Section 1 – General Alcohol Module

These questions ask for your opinions about alcohol. I am going to read some statements, and I would like you to choose a number between 1 and 7, where 1 means you totally disagree, 4 means you are neutral, and 7 means you totally agree with the statement. So, the higher the number, the more you agree with the statement. Remember, there are no right or wrong answers.

FINALSAY

1. People with an alcohol problem should have the final say over whether or not they receive treatment.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

FORCED

2. The best way to help someone with an alcohol problem is to force him/her into treatment.

Completely						Strongly	Don't	No

Disagree Neutral Agree Know Response

1 2 3 4 5 6 7 9 0

DECIDE

3. People should be allowed to decide for themselves whether or not they go into treatment for an alcohol problem.

Completely Strongly Don't No

Disagree Neutral Agree Know Response

1 2 3 4 5 6 7 9 0

LAW

4. Anyone who has an alcohol problem should be required by law to enter treatment programs.

Completely Strongly Don't No

Disagree Neutral Agree Know Response

1 2 3 4 5 6 7 9 0

CRIME

5. People with an alcohol problem who are guilty of committing crimes to support their habit should be required to receive treatment.

Completely Strongly Don't No

Disagree Neutral Agree Know Response

1 2 3 4 5 6 7 9 0

REJECT1

6. People who have hurt others or caused damage by their drinking should be free to accept or reject treatment.

Completely						Strongly	Don't	No
Disagree			Neutral			Agree	Know	Response
1	2	3	4	5	6	7	9	0

TEST

7. People with an alcohol problem should be tested regularly in order to maintain their employment.

Completely						Strongly	Don't	No
Disagree			Neutral			Agree	Know	Response
1	2	3	4	5	6	7	9	0

JOBTEST

8. People with an alcohol problem should be free to accept or reject testing as a condition of employment.

Completely						Strongly	Don't	No
Disagree			Neutral			Agree	Know	Response
1	2	3	4	5	6	7	9	0

ALLOWED

9. People with an alcohol problem should not be able to drink anywhere they want.

Completely						Strongly	Don't	No
Disagree			Neutral			Agree	Know	Response
1	2	3	4	5	6	7	9	0

WHERE

10. People with an alcohol problem should be free to drink anywhere they want.

Completely Strongly Don't No

Disagree Neutral Agree Know Response

1 2 3 4 5 6 7 9 0

For the next set of questions, I would like you to imagine that you are making each statement. Continue to indicate whether you agree or disagree with the statement.

CONVINC

11. If someone I knew had an alcohol problem, I would try to convince them to cut down or stop drinking.

Completely Strongly Don't No

Disagree Neutral Agree Know Response

1 2 3 4 5 6 7 9 0

MYAGE

12. People my age think it is a good idea to try to convince someone with an alcohol problem to cut down or stop drinking.

Completely Strongly Don't No

Disagree Neutral Agree Know Response

1 2 3 4 5 6 7 9 0

ABILITY

13. I am confident in my ability to convince someone with an alcohol problem to cut down or stop drinking.

Completely Strongly Don't No
Disagree Neutral Agree Know Response
1 2 3 4 5 6 7 9 0

CUTDOWN

14. I think it would be wrong to try to convince someone with an alcohol problem to cut down or stop drinking.

Completely Strongly Don't No
Disagree Neutral Agree Know Response
1 2 3 4 5 6 7 9 0

KNEW

15. If someone I knew had an alcohol problem, I would arrange for them to enter a treatment program.

Completely Strongly Don't No
Disagree Neutral Agree Know Response
1 2 3 4 5 6 7 9 0

THINK

16. People my age think it is a good idea to arrange for someone with an alcohol problem to enter a treatment program.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

ENTER

17. I am confident in my ability to convince someone with an alcohol problem to enter a treatment program.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

WRONG

18. I think it would be wrong to arrange for someone with an alcohol problem to enter a treatment program.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

THREAT

19. If someone I knew had an alcohol problem, I would threaten them in order to get them to cut down or stop drinking.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

STOP

20. People my age think it is a good idea to threaten someone with an alcohol problem to get him/her to cut down or stop drinking.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

CONFID

21. I am confident in my ability to threaten someone with an alcohol problem to get him/her to cut down or stop drinking.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

XSTOP

22. I think it would be wrong to threaten someone with an alcohol problem to get him/her to cut down or stop drinking.

Completely Strongly Don't No
Disagree Neutral Agree Know Response
1 2 3 4 5 6 7 9 0

RESPONS

23. Anybody with an alcohol problem is personally responsible for the development of his or her problem.

Completely Strongly Don't No
Disagree Neutral Agree Know Response
1 2 3 4 5 6 7 9 0

WASTE

24. Trying to change a person's drinking habits is a waste of time unless you change their environment.

Completely Strongly Don't No
Disagree Neutral Agree Know Response
1 2 3 4 5 6 7 9 0

BEHAVE

25. Anybody with an alcohol problem is personally responsible for changing his/her behaviour.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

DISEASE

26. Anybody with an alcohol problem has a disease and cannot change their behaviour without outside help.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

SOCIETY

27. Society should do everything possible to help problem drinkers.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

SOCIETY2

28. Society should do everything possible to help family and friends affected by problem drinkers.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

KNOWN

29. Have you personally known someone who had an alcohol problem?

1 Yes

2 No

9 Don't know

0 No response

Appendix 3: Pregnancy and Alcohol Module Survey Questions

Section 2 – Pregnancy & Alcohol Module

These questions ask for your opinions about pregnancy and alcohol. I am going to read some statements, and I would like you to choose a number between 1 and 7, where 1 means you totally disagree, 4 means you are neutral, and 7 means you totally agree with the statement. So, the higher the number, the more you agree with the statement. Remember, there are no right or wrong answers.

PREG

1. Pregnant women should be allowed to decide for themselves whether or not they will consume alcohol.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PFINAL

2. Pregnant women with an alcohol problem should have the final say over whether or not they receive treatment.

Completely						Strongly	Don't	No
Disagree			Neutral			Agree	Know	Response
1	2	3	4	5	6	7	9	0

PFORCED

3. The best way to help a pregnant woman with an alcohol problem is to force her into treatment.

Completely						Strongly	Don't	No
Disagree			Neutral			Agree	Know	Response
1	2	3	4	5	6	7	9	0

PDECIDE

4. Pregnant women should be allowed to decide for themselves whether or not they go into treatment for an alcohol problem.

Completely						Strongly	Don't	No
Disagree			Neutral			Agree	Know	Response
1	2	3	4	5	6	7	9	0

PLAW

5. Any woman who is pregnant and has an alcohol problem should be required by law to enter a treatment program.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PCRIME

6. Pregnant women with an alcohol problem, who are guilty of committing crimes to support their habit should be required to receive treatment.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PREJECT

7. Pregnant women who might be causing damage to their fetus by drinking alcohol should be free to accept or reject treatment.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PTEST

8. Pregnant women with an alcohol problem should be tested regularly in order to maintain their employment.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PJOBTEST

9. Pregnant women with an alcohol problem should be free to accept or reject testing as a condition of employment.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PALLOWED

10. Pregnant women with an alcohol problem should not be able to drink anywhere they want.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PWHERE

11. Pregnant women with an alcohol problem should be free to drink anywhere they want.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

For the next set of questions, I would like you to imagine that you are making each statement. Continue to indicate whether you agree or disagree with the statement.

PCONVINC

12. If I knew a pregnant woman with an alcohol problem, I would try to convince her to cut down or stop drinking.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PMYAGE

13. People my age think it is a good idea to try to convince a pregnant woman who consumes alcohol to cut down or stop drinking.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PABILITY

14. I am confident in my ability to convince a pregnant woman with an alcohol problem to cut down or stop drinking.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PCUTDOWN

15. I think it would be wrong to try to convince a pregnant woman with an alcohol problem to cut down or stop drinking.

Completely Disagree			Neutral		Strongly Agree		Don't Know	No Response
1	2	3	4	5	6	7	9	0

PKNEW

16. If I knew a pregnant woman with an alcohol problem, I would arrange for her to enter a treatment program.

Completely Disagree			Neutral		Strongly Agree		Don't Know	No Response
1	2	3	4	5	6	7	9	0

PTHINK

17. People my age think it is a good idea to arrange for a pregnant woman with an alcohol problem to enter a treatment program.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PENTER

18. I am confident in my ability to convince a pregnant woman with an alcohol problem to enter a treatment program.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PWRONG

19. I think it would be wrong to arrange for a pregnant woman with an alcohol problem to enter a treatment program.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PTHREAT

20. If I knew a pregnant woman with an alcohol problem, I would threaten her in order to get her to cut down or stop drinking.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PSTOP

21. People my age think it is a good idea to threaten a pregnant woman with an alcohol problem to get her to cut down or stop drinking.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PCONFID

22. I am confident in my ability to threaten a pregnant woman with an alcohol problem to get her to cut down or stop drinking.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PXSTOP

23. I think it would be wrong to threaten a pregnant woman with an alcohol problem to get her to cut down or stop drinking.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PRESPONS

24. A pregnant woman with an alcohol problem is personally responsible for the development of her problem

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PWASTE

25. Trying to change a pregnant woman's drinking habits is a waste of time unless you change her environment.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PBEHAVE

26. A pregnant woman with an alcohol problem is personally responsible for changing her behaviour.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PDAMAGE

27. A pregnant woman with an alcohol problem is personally responsible for any damage caused to the fetus by alcohol.

Completely Disagree			Neutral			Strongly Agree	Don't Know	No Response
1	2	3	4	5	6	7	9	0

PDISEASE

28. A pregnant woman with an alcohol problem has a disease and cannot change her behaviour without outside help.

Completely						Strongly	Don't	No
Disagree			Neutral			Agree	Know	Response
1	2	3	4	5	6	7	9	0

PSOCIETY

29. Society should do everything possible to help pregnant women with drinking problems.

Completely						Strongly	Don't	No
Disagree			Neutral			Agree	Know	Response
1	2	3	4	5	6	7	9	0

PSOC2

30. Society should do everything possible to make sure women with drinking problems do not give birth to children with fetal alcohol syndrome.

Completely						Strongly	Don't	No
Disagree			Neutral			Agree	Know	Response
1	2	3	4	5	6	7	9	0

PKNOWN

31. Have you personally known a woman who had an alcohol problem while she was pregnant?

1	Yes
2	No
9	Don’t know
0	No response

PARENT

32. Are you a parent yourself?

1	Yes
2	No
9	Don’t know
0	No response

Appendix 4: Sociodemographic Module Survey Questions

Section 9 -- Sociodemographic Module

These next questions will give us a better picture of the people who took part in this study.

SEX

1. Enter gender of respondent (DO NOT ASK)

1	Male
2	Female

AGE

2. Could you please tell me your age? __________

MARITAL

3. What is your current marital status? ... (READ)

1	Married/common-law
2	Separated/divorced
3	Widowed
4	Single/never married

9	Don’t know
0	No response

EMPLOY

4. Which one of the following best describes your current employment status?

….(READ)

1	Employed 30 hours per week or more (including self-employed)
2	Employed less than 30 hours per week (including self-employed)
3	Unemployed
4	Student
5	Homemaker
6	Retired
7	Disabled (disability pension, AISH)
8	Other (specify)____________________
9	Don’t know
0	No response

INTERVIEWER NOTE: IF respondent fits more than one category, ask him/her to select ONE that best describes his/her status.

INTERVIEWER NOTE: IF respondent works more than one job and total hours of these jobs are 30 or more, choose "1". IF respondent works more than one job and total hours of those jobs are less than 30, choose "2". PLEASE DO NOT DETAIL THIS INFORMATION IN OTHER.

EDUC

5. What is the highest level of education that you have obtained? ….. (READ)

1 Grade 9 or less
2 Some high school
3 High school diploma
4 Some university/college/technical school (e.g., NAIT, SAIT)
5 University degree/college diploma/technical school diploma
6 Other (specify) ____________________

9 Don't know
0 No response

INCOME

6. What was your total household income, before taxes, last year? …… (READ)

1 Under $20,000
2 $20,000 - 29,999
7 $70,000 - 79,999
8 $80,000 - 89,999

3	$30,000 - 39,999	9	$90,000 - 99,999
4	$40,000 - 49,999	10	$100,000 or more
5	$50,000 - 59,999	11	Don't know
6	$60,000 - 69,999	0	No response

INTERVIEWER PROBE (for reluctant respondent): WE WERE JUST LOOKING FOR A BALLPARK FIGURE…

INTERVIEWER NOTE: IF RESPONDENT SAYS "PENSION" BU CAN NOT OR WON'T TELL YOU $ AMOUNT, CHOOSE < $20,000.

CONTACT

7. Would it be alright for us to contact you again by telephone in the future to participate in another study?

1	Yes
2	No (Skip to THANKS)
9	Don't know
0	No response

NAMEMay I please ask for your first name or initial so that we know who to ask for?

____

THANKS

We have reached the end of our interview today. I would like to thank you very much for your time and interest in this study.

DECLARE

I declare that this interview was conducted in accordance with the interviewing and sampling instructions given by the Population Research Laboratory. I agree that the content of this survey and all respondent's responses will be kept confidential. Please enter your interviewer number to proceed.

LENGTH

Record length of interview (in minutes)

SEX2

Re-enter the sex of the respondent.

1 Male

2 Female